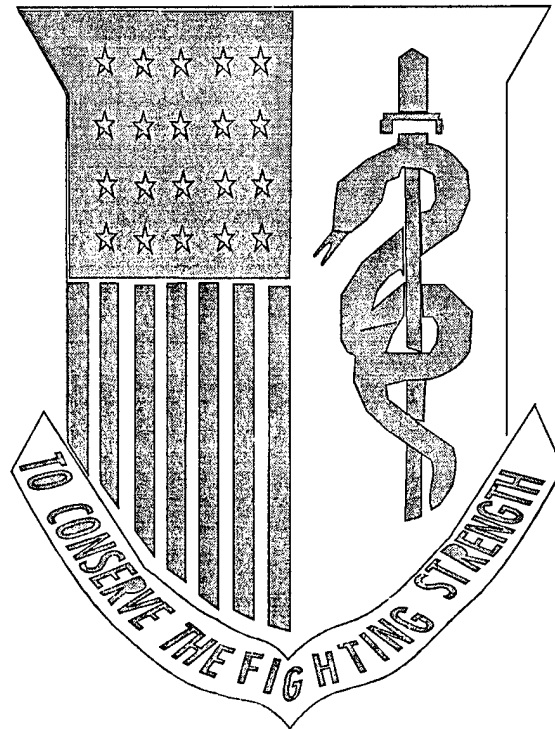


UNITED STATES ARMY MEDICAL DEPARTMENT

REORGANIZATION



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VOLUME I
NARRATIVE

DTIC QUALITY INSPECTED 8



TASK FORCE AESCULAPIUS
JANUARY 1993 - JUNE 1995



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REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258




DASG-TT

16 June 1995

MEMORANDUM FOR THE SURGEON GENERAL

SUBJECT: Army Medical Department Reorganization, January 1993 -
June 1995

1. One of the goals of your tenure as The Surgeon General was to effect the changes necessary to move the Army Medical Department into the 21st Century. You chartered Task Force Aesculapius to assist you in this goal by working as change agents and facilitators for reorganization. While the true success of our endeavors will only be measured by time, General Sullivan's designation of the U.S. Army Medical Command as the first Force XXI MACOM is an indicator of the AMEDD's current azimuth.
2. Attached is a synopsis of the work of the Task Force over the last two and one-half years. This report is intended to provide a historical record of the change process you initiated as well as a reference document for any future analyses.
3. I appreciate the opportunity to have been a part of one of the most significant reorganizations in the Army Medical Department's history.


RUSS ZAJCHUK
BG, MC
Project Manager,
Task Force Aesculapius

UNITED STATES ARMY MEDICAL DEPARTMENT
REORGANIZATION

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UNITED STATES ARMY MEDICAL DEPARTMENT
REORGANIZATION

EXECUTIVE SUMMARY

Task Force Aesculapius (TFA) was chartered by The Surgeon General (TSG) in early 1993 to recommend alignment of the mission, functions, and structure of the Army Medical Department (AMEDD) to support its strategic vision and prepare an implementation plan for the transformation of the AMEDD. What follows is a compilation of the activities of TFA and results of the AMEDD reorganization from its inception in January 1993 until closure of the task force office in June 1995.

The reorganized AMEDD is streamlined and flattened, transformed into a seamless organization that connects the sustaining base directly to the battlefield. The new Medical Command (MEDCOM) supports the AMEDD vision, linking AMEDD assets worldwide into a high-quality, cost-effective, and accessible health care organization serving the Total Army Family across the globe. Previous functional overlaps, inefficiencies, and operational voids have been eliminated. The MEDCOM integrates key organizational and doctrinal changes within the Army and health care that position the AMEDD to be more effective and efficient into the next century. Recognizing the progressive organizational changes the AMEDD has made, the Chief of Staff of the Army (CSA) recently referred to the newly created MEDCOM as

the first Force XXI MACOM.

The CSA has always held TSG accountable for medically-related matters. By dual-hatting TSG as the MEDCOM Commander, he now has the authority for administering worldwide health care commensurate with his accountability. The major subordinate commands (MSCs) of the MEDCOM are better organized around specific product lines, accountable to the MEDCOM Commander, and better linked to provide their various services to the soldier, family members, and eligible beneficiaries.

This document presents the background factors leading to the AMEDD reorganization, the analytical process used, the approval process, outcomes of concept development, and implementation of the concept. Other related topics such as information management, marketing, corps chiefs, general officer distribution, etc. are also discussed. Supporting documents are provided as enclosures.

AMEDD REORGANIZATION
PHASE I: CONCEPT DEVELOPMENT

I. BACKGROUND

The U.S. Army Medical Department (AMEDD) is currently undergoing its most extensive reorganization since the 1940's. This reorganization came about for a number of reasons. The demise of the Soviet Union and the concomitant shift from a bipolar world to a multipolar world have resulted in demands for a smaller and more efficient Army. Constrained resources have become a fact of life. A growing social awareness regarding the size and growth of the national debt, exacerbated by the sheer size of the government establishment, has generated widespread public demand for smaller, more efficient government agencies. The Department of Defense has not escaped these pressures. In fact, DoD's share of the overall reduction goal is, by far the largest of any government agency. The AMEDD, like all other Army Departments or MACOMS, must participate in the downsizing of the force.

Simultaneously, however, national health care reform is forcing the AMEDD to compete to serve beneficiaries who fall into the other than active duty population. This competition necessitates the development of new programs and policies. In addition, flaws in existing headquarters elements have been apparent for a number of years.

Phase I of this paper reviews the reasons behind the

reorganization, the underlying theoretical construct of the new design, the process of the restructuring, and an overview of the command and control structure of the newly designed organization. Phase II covers implementation considerations and strategy, major subordinate command analyses (minus HSSAs), and some key issues related to the reorganization. Since the transition to the new organizational design is continuing, the paper will conclude with the status of the reorganization as of Summer 1995. After that time, transition monitoring and facilitation is being transferred from Task Force Aesculapius (discussed later) to the U.S. Army Medical Command Transition Office.

From a theoretical perspective there are a number of circumstances that stimulate impetus for reorganization.

Kimberly defined these circumstances as follows:¹

1. When an organization experiences problems.
2. When there is a change in the environment which directly influences internal policies.
3. When new programs or product lines are targeted by a changing mission statement.
4. When there is a change in leadership.

Each of these situations was involved to some extent in the decision to reorganize the AMEDD. As the prevailing national and international political environment changed, all four of these

¹ J.R. Kimberly, "The Anatomy of Organizational Design," Journal of Management, 1984, 10(1), 109-126.

conditions became operative in the AMEDD environment. For example:

1. Existing organizational problems. There is no question that the existing AMEDD organizational structure was experiencing problems. Some of the problems were associated with working relationship issues between the Office of the Surgeon General (OTSG) and Headquarters, Health Services Command (HSC) or between the OTSG staff and HSC internal subordinate commands. Other problems were generated by HSC's span of control. These issues are well documented in the 1987 U.S. Army Medical Department Command and Control Study (also known as the Van Stratten Study) commissioned by then Surgeon General, LTG Quinn H. Becker. This study was a primary reference document for Task Force Aesculapius, the special task force chartered to carry out the current reorganization work. The May 1988 Medical Bulletin of the US Army Medical Department contains an overview of the Command and Control Study but the Study should be reviewed in its entirety by anyone desiring to develop an in-depth understanding of the historical aspects of the current reorganization.

2. Environmental changes. During 1992, multiple external forces pressured the AMEDD to change in order to keep up with a rapidly changing environment. For example, an ongoing HQDA Transformation Study was charged by the CSA to determine the optimal HQDA structure for the future. The underlying intent of this study was to reduce the size of the Army Staff (ARSTAF). Recognizing this intent, TSG asked for and was granted permission

to conduct an independent reorganization analysis and report out the results to the Army leadership by July 1993. Another major change in 1992 was the inauguration of the Clinton Administration and its National Health Care Reform initiative. With the new Administration came a change in leadership and focus within the Office of the Assistant Secretary of Defense for Health Affairs (ASD(HA)) and a renewed interest in the concept of a Defense Health Agency. The Office of the Secretary of Defense (OSD) "Bottom-up" Review and the Congressionally mandated 733 Study were ongoing during this period and heightened awareness within the AMEDD for the need to restructure in order to achieve maximum efficiencies.

3. Changing mission and vision. The CSA's vision statement reflected the tremendous impact the new world order had on changing the Army's mission and force structure concept. Force XXI became the new umbrella concept outlining how the Army intended to execute the national military strategy. The concept enabled the Army to support worldwide operational missions from a CONUS based force projection platform. TSG, in turn, developed a supporting vision statement to reinforce the Force XXI umbrella concept. LTG LaNoue's vision statement became:

AMEDD VISION

THE ARMY MEDICAL DEPARTMENT -- A world class system for total quality health care in support of America's Army at home and abroad, accessible to the total Army family, accountable to the American people.

LTG LaNoue's vision appropriately focused the AMEDD toward supporting GEN Sullivan's Force XXI concept, maintaining or improving technological superiority, mobility, flexibility, high quality, and Reserve Component integration while balancing accessibility and accountability. Implied in this vision is the need to provide medical care for a digitized force and a shift in mission from supporting large, global conflicts to supporting multiple small contingencies, humanitarian and natural disaster relief efforts.

4. Change in leadership. The fourth catalyst which stimulated impetus for reorganization was the change in leadership which occurred in the summer of 1992, when LTG Alcide M. LaNoue became The Army Surgeon General. Prior to assuming the Surgeon General mantle, LTG LaNoue had initiated a pilot organizational design study, using Organizational Design, Incorporated (ODI) as an independent contractor, within Health Services Command. A description of the methodology of the pilot study is summarized in the Analytical Process section of this paper. A primary output of the initial study involved a recommendation to apply the same underlying theory and principles to the entire HSC headquarters. As TSG, LTG LaNoue took the recommendation one step further and decided to analyze and restructure the entire AMEDD.

To effectively carry out a study of this magnitude it was further recommended that a separate General Officer led task force be established. Additionally, the task force was to be

unfettered from other responsibilities and would report directly to TSG. He appointed MG Girard Seitter III, as head of a reorganization task force named Task Force Aesculapius (TFA) - also initially referred to as Project AMEDD Vanguard. Considerable thought went into the Task Force name selection process. TFA was named for Aesculapius, the Greek God of healing. The traditional symbol of the AMEDD is the caduceus, a winged staff with two serpents twined around it which, in ancient times, represented the staff of Hermes. One of Hermes' appointments was to conduct the souls of the dead to Hell. Its wide spread use as a symbol representative of the medical profession has been a matter of controversy for years. Most scholars feel the staff of Aesculapius is a more appropriate symbol. The significance of this symbology was not lost when LTG LaNoue appointed Task Force Aesculapius to redesign the AMEDD and, in the process, make it a more efficient organization to support Army's Force XXI.

After being selected to head up the task force, MG Seitter was given broad initial guidance on how the reorganization should proceed. Likewise, he was given almost unlimited latitude on how to organize and utilize the Task Force. In organizing the Task Force, MG Seitter elected to employ representation from each of the six AMEDD officer Corps and the AMEDD enlisted corps. This representation was significant for a variety of reasons, the most important being initiation of stakeholder participation in the reorganization process. Each Corps Chief was contacted and

requested to provide names of suitable candidates to serve on the Task Force. After an interview process, individuals deemed best qualified were selected. A civilian member was not included on the Task Force and, in retrospect, should have been since civilian stakeholder buy-in to the process was vital to the success of the reorganization. This shortfall was eventually overcome by frequently including AMEDD civilian employees as consultants; in all working group meetings; and in the interview, data collection and analysis process. Additionally, a TFA recommendation to establish a Civilian Workforce Resizing Process Action Team (CIVPAT) was adopted in July 1993. The CIVPAT leader worked closely with TFA and this became an invaluable communication conduit between the civilian workforce and TFA.

One of the first tasks of the assembled Task Force was to develop a Charter to insure that each Task Force member clearly understood the requirements of the project and to insure that the initial guidance of TSG was in concert with the mission of the Task Force. The charter and a listing of the original Task Force members is shown at Enclosure 1. After it was developed, the charter was continually used to maintain the focus of the Task Force and as a "calling card" for subsequent TFA work. It proved to be a concise, effective tool for explaining the objectives of the project.

Very early in the process, a conscious decision was made to devote a week of off-site time for the Task Force to undergo a team building exercise. Because of its reputation and widespread

use by the senior Army leadership, the Center for Creative Leadership in Greensboro, North Carolina, was chosen for this exercise. This week proved to be extremely useful in facilitating completion of Phase I of the reorganization. The time line of getting a Concept Plan to the CSA by July was so compressed that use of all resources had to be maximized. Being able to work together as an efficient, cohesive team was deemed invaluable in meeting such a deadline.

II. ANALYTICAL PROCESS - The analytical process during Phase I resulted in detailed recommendations for reorganizing the Office of the Surgeon General; establishing a U.S. Army Medical Command; a conceptual Health Services Support Area (HSSA) Staff recommendation; and an overview analysis of some of the major subordinate commands (MSC) of the MEDCOM. An in-depth analysis of the MSCs took place during phase II.

A.. The Role of Task Force Aesculapius

Task Force Aesculapius focused on several vital roles in the AMEDD reorganization. As reflected in their charter, the mission of the Task Force was to recommend to TSG an AMEDD organization that best supported the AMEDD vision. To do this, TFA was concurrently an integrator, a change agent, an honest broker, and a facilitator. TFA's analytical process proceeded along several parallel lines which included a historical review of past AMEDD reorganizations, stakeholder interviews, developing benchmark

data and conducting an environmental assessment.

There have been several reorganizations or reorganization proposals/studies conducted in the last 30 years. These include the Wadhams Committee Investigation in 1963, the 1969 Worldwide Organizational Structure for Army Medical Support (WORSAMS) study, the Class I and II organizations before Health Services Command (HSC), the 1973 HSC reorganization, the 1977 OTSG reorganization and the 1987 AMEDD Command and Control Study. All these actions were reviewed during an in-depth interview of Dr. Robert Joy, the unofficial AMEDD Historian, by TFA. They were later studied in detail by the Task Force and represented a solid foundation for the historical review on which this reorganization is based.

Many detailed interviews of senior leaders both in and outside of the AMEDD were conducted (interview list is at Enclosure 2). These were used as a basis to determine the expectations of key internal and external stakeholders of the AMEDD as related to capabilities of the AMEDD. The Army Corps of Engineers and Headquarters, Department of the Army, were in varying stages of reorganization efforts as the AMEDD reorganization began. Both these efforts were reviewed in detail as a part of benchmarking the work of the Task Force. Because of the dynamic arena in which health care exists today, environmental assessment was an extremely important part of the reorganization work. This assessment consisted of closely following the progress of the National Health Care Reform Task

Force; interviewing staff employees of Congressional members with interest or influence over the AMEDD; and close liaison with all the Army MACOMS, DA Staff, and the Office of the Assistant Secretary of Defense for Health Affairs (ASD(HA)). Finally, the sage advice of GEN(R) Maxwell R. Thurman was solicited frequently, from both a customer and political perspective. His insight and wisdom were invaluable throughout the process.

B. The Role of Organizational Design, Incorporated (ODI)

1. Philosophical Underpinnings

This portion of the AMEDD reorganization effort was based on the application of a unique methodological approach shown in Figure 1. The basic philosophical premise of ODI's approach is based on the concept that organizations exist in the first place to get work done. That is what they are all about. And, in a general sense, any organization is likely to function more effectively when it is designed specifically around the work rather than around other spurious considerations such as historical requirements, pay grades, or the personalities of the people involved.

Work, as used in this study, is made up of tasks, goals and objectives. What makes work so important from a design perspective is that tasks, goals and objectives come in varying degrees of complexity. It is the intrinsic complexity of tasks which subsequently dictates the number of managerial layers and the corresponding type of roles necessary to get the work done

ORGANIZATIONAL DESIGN

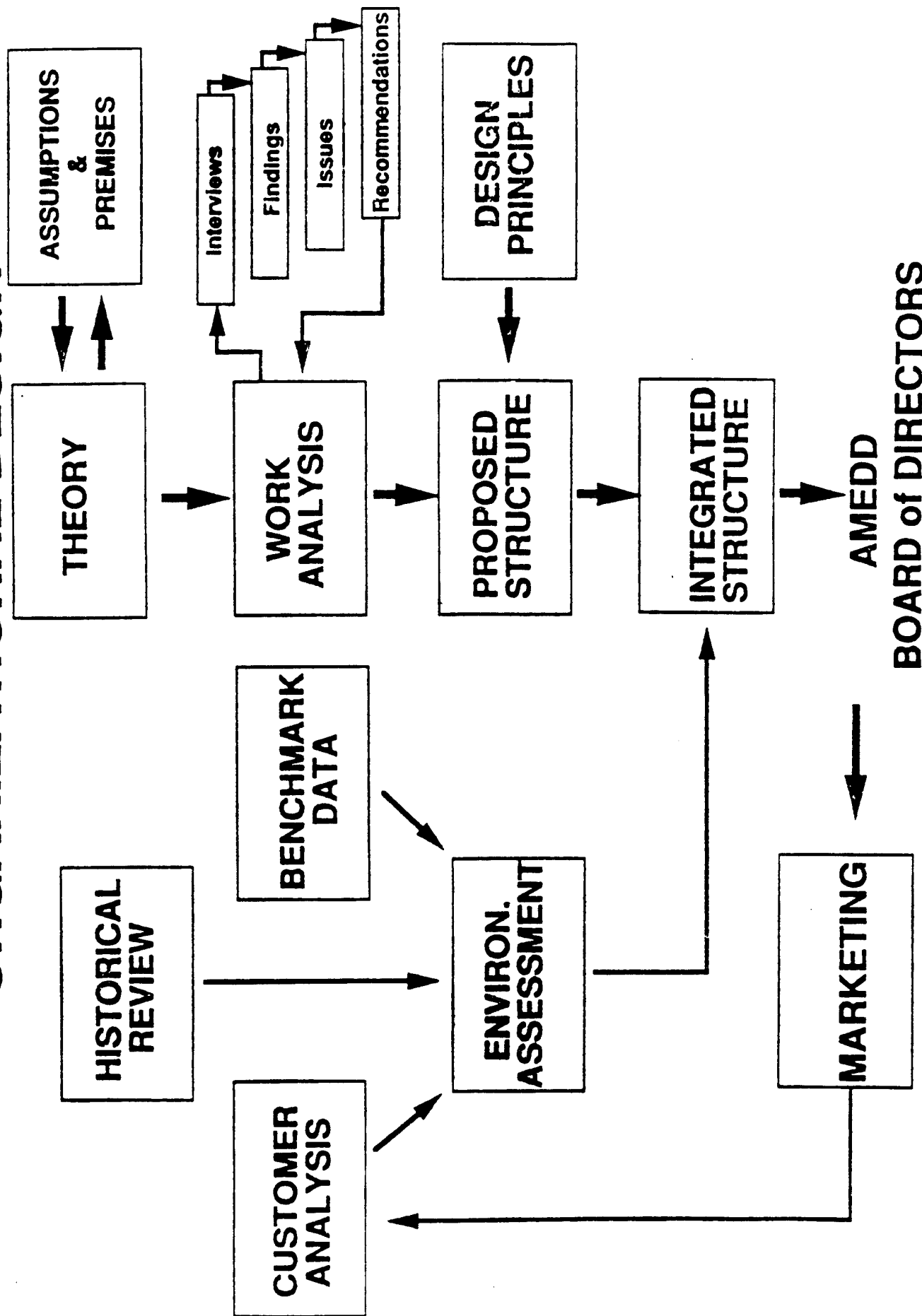


FIGURE 1

effectively. The number of layers, in turn, profoundly affects a manager's capacity to "add value." For example, "too many layers" means that managers are likely to be grouped too closely together with the resulting effect that each is prone to get in the way of the others. In order to add value to the work of a subordinate, a manager needs to be at least one full level of capability higher than the subordinate (e.g., able to solve problems of at least one full degree of complexity greater than the subordinate). When managers do not possess sufficient capability to solve such problems they tend to work on problems of a lower degree of complexity. In other words, they tend to work on the same tasks as their subordinates.

While designing an organization's structure correctly is essential for ensuring effectiveness, it is by no means wholly sufficient. It is also important to ensure that the supporting managerial systems (e.g., the task assignment system, the planning system, and the performance appraisal system) are also optimally designed. Figure 2 illustrates the steps involved in improving leader development and achieving a true competitive edge.

It should come as no surprise that the above managerial systems are central to driving or reinforcing specific behaviors. If such systems are not congruent with desired managerial behaviors, then the systems themselves will often be paramount in producing selected dysfunctional outcomes.

SIX STEPS TO SOUND ORGANIZATION AND LEADERSHIP

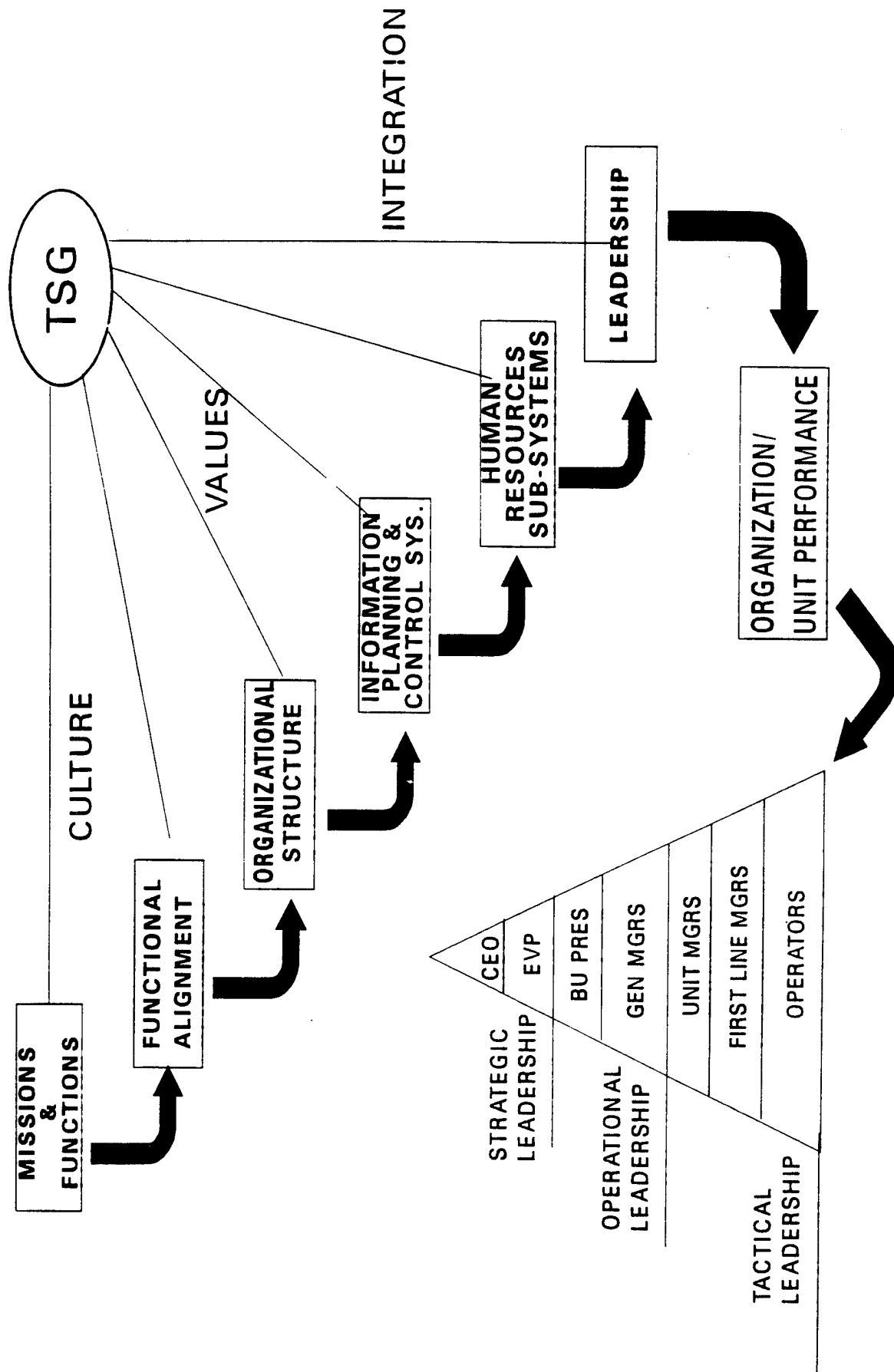


FIGURE 2

2. Stratified Systems Theory

The concepts and principles utilized in this effort were based on Stratified Systems Theory (SST) as an underlying organizational theory. These concepts were developed over a three decade period at Brunell University in London and were supported in their development phase by a series of grants from the Army Research Institute (ARI). Stratified Systems Theory expresses a philosophy of the organization of work. The theory proposes that it is possible to design optimum conditions (requisite ones) in which work may be done efficiently and effectively. The theory arose from the discovery, through widespread testing over a number of years in many public and private organizations, of a systematic structure of successive layers within bureaucratic organizations, with each layer "adding value" to the work of the next lower layer. The aim of SST is to provide a systematic approach to the organization of work and the identification of methods for getting that work done.

3. Army Medical Department Work

The work of the AMEDD is twofold. First, it is to assist the Army Chief of Staff in all medical matters pertaining to the deployment of U.S. Army ground combat forces. Second, it is to provide cost effective, world class health care to eligible beneficiaries in the sustaining base of the Army. The fact that the world political and military environment is in an unprecedented state of flux simply means that the basic work of

the AMEDD must also be in a continual state of adjustment. Practically speaking, in today's environment change is the only true constant. Nevertheless, it is possible to identify the underlying complexity of providing strategic direction regarding the potential employment of medical forces and in delivering cost effective, accessible world class health care. Once that is done, it logically follows to establish the correct set of organizational functions required therein, align such functions into a requisite organizational structure, and establish clear accountabilities and authorities for carrying out such work. Finally, it is also possible to identify a set of effective and trainable managerial practices that go along with and enhance a requisite structure.

4. ODI's Technical Approach to Work Analysis

A cornerstone of ODI's approach to organizational design is to first develop a clear understanding of the exact nature of the work assigned to the organization. This meant identifying and evaluating the inherent complexity of the tasks assigned to or required of the AMEDD. Once task complexity had been identified, it was then possible to determine the exact number of managerial layers required to carry out such work. This was done by comparing the actual work data with a theoretical work pattern discovered over the years through the systematic application of SST principles to similar work systems.

The actual process for carrying out the above comparison was

to describe the work system in the Army Medical Department from three perspectives. First, we described the manifest organization; i.e., the organization depicted on the current organization chart. Next, the manifest organization was contrasted with the extant organization; the organization reflecting how work actually gets carried out. Finally, we compared both these structures with the requisite structure, the ideal organization necessary to handle the complexity of assigned work. The degree of congruence between these three systems is likely to yield a number of findings that have significant organizational implications; e.g., too many managers at a given layer, a missing layer, etc. These findings are then combined with other data according to the following rigorous analytical process.

5. The Analytical Process

The heart of this effort involved conducting a number of in-depth interviews with AMEDD personnel in existing organizations. These interviews were designed specifically around those SST principles referred to previously. Considerable research experience over the years has found that these principles are useful in getting at the core issues affecting any organization's work system. Each interview lasted approximately two hours and the data they produced was subsequently subjected to the following step wise analytical procedures:

- a. The interviews yielded qualitative data in the form of

statements, observations, or opinions. Statements represent an interviewee's description of an event; observations are a perception about something; and opinions are a reflection of an interviewee's judgment.

b. Statements, observations and opinions were then aggregated and subsequently synthesized into themes. A theme is an element common to a number of statements, observations and opinions.

c. An analysis of themes, in turn, yielded a project finding. A finding is defined as a "pronouncement" made by the ODI interview team regarding something that they have judged to be based upon factual interview data.

d. Findings also lead to a description of the extant organization; the organization as it actually functions in a day-to-day operational mode.

e. A comparison was then drawn between the manifest organization (the organization as depicted on the organization chart), the extant organization (the de facto organization presently employed to get the work done), and the requisite organization (the optimal organization designed to cope with the complexity of the work). This comparison yielded additional project findings.

f. An analysis of findings subsequently leads to their transformation into underlying issue statements. Issue statements are described in two distinct ways; the first is a restatement of the basic finding in the context of its probable

relationship with the future; the second aspect is to reformulate the finding as a question with the answer leading directly to the resolution of the finding.

g. Project findings and issues were then "extruded" through a "die" of basic organizational design principles to yield a proposed organizational structure and an accompanying set of project recommendations.

6. Interview Process

The actual interview process began by providing each organization (or staff section) with an overview briefing of the underlying theory and philosophical underpinnings supporting the study effort. The briefing was designed to allay any fears or squelch potential rumors pertaining to the interview process.

7. Feedback

The analytical process generated a number of issue papers pertaining to each organizational unit (or staff section). A sample of an issue paper is at Enclosure 3. Each issue paper was supported by relevant visual supporting material, also at Enclosure 3. Copies of all issue papers and supporting graphics and/or illustrations were then provided to each affected organizational unit (or staff element). All organizations (or staff section) were offered an opportunity to officially respond and/or comment about any issue paper or proposed recommendation. These comments, along with the original issue papers were

subsequently provided to a series of functional working groups for overall integration (for a more complete discussion of the integration process refer to section IIc).

A principle outcome of the work analysis process was the construction of a straw man organizational structure for each work unit studied. The straw man was constructed through the application of a set of theoretical organizational design principles which are outlined and discussed in ODI's presentation entitled *Executive Leadership Principles* (see Enclosure 4). These principles focus on the nature and complexity of work. By analyzing the complexity of the work inherent in achieving an organization's basic mission, one is able to construct the proper (i.e., the requisite) number of organizational layers required to effectively manage such work. The principles also facilitate a clearer differentiation between strategic, operational and tactical levels of work.

C. Process Integration

Early data collection in the AMEDD restructuring effort followed a bifurcated process as illustrated in Figure 1. The TFA team carried out the steps illustrated on the left; i.e., they analyzed historical restructuring efforts; conducted a set of stakeholder interviews; gathered benchmarking data; and initiated an environmental assessment. Simultaneously; the Organizational Design, Inc. team conducted a detailed assessment of the work in a given organization (or section); illustrated on

the right side of Figure 1.

The work assessment data consisted of a large number of in-depth interviews, conducted by ODI, structured specifically around the work inherent in a given role. The data yielded an overall analysis of the work and its underlying complexity base. The ODI team subsequently applied a number of design principles to the work analysis which, in turn, led to the development of straw man organizational structures for the Office of the Surgeon General, MEDCOM Headquarters and HSSA Headquarters.

The integration process began with the Task Force hosting and conducting a number of focus groups. First, the straw man structures for OTSG, MEDCOM and HSSAs along with the underlying work analyses (e.g. issue papers and customer responses) were provided to TFA by ODI. After review and integration with TFA's own data, this material was presented in the form of a detailed study book to a subject matter expert (SME) work group, called Fair Oaks I. (It was termed Fair Oaks I because it was the first of two similar meetings conducted at a hotel in the Fair Oaks region of Fairfax, Virginia.) The work group consisted of approximately fifty functional experts from the MEDCOM (at that time, HSC), OTSG, and selected subordinate commands. The work group was chartered to analyze the straw man position; differentiate between strategic, operational and tactical level work; identify overlaps and voids; prepare recommendations to deal with same; and propose an initial set of staffing recommendations appropriate to each level. A secondary, but

equally important, purpose of the work group was to elicit stakeholder participation in the reorganization process. This participation proved to be instrumental in subsequent marketing of the reorganization plan. After several days of intensive review, the analyses of various break-out groups were presented in a plenary session to TFA.

The Task Force then collected and reviewed all assembled data at an off-site session at Kent Island, Maryland. This meeting was a thorough dissection and reassembly of all proposals. A principle outcome of this effort was the development of an in-progress review (IPR) for TSG (see Enclosure 5). The IPR outlined a number of major decision points requiring TSG approval and/or further guidance. The following items listed the major points discussed in this IPR.

1. ARSTAF
 - Location and functions
2. MEDCOM
 - Formation and location
 - Commander, rank, and location
 - Functions
3. Regions
 - Number and report chain
 - Commander rank
 - Functions

Having received guidance from TSG, TFA then made a detailed two day presentation of the interim recommendations to the AMEDD

Senior Executive Council (ASEC). This body provided further guidance but generally approved TFA work up through that time. The presentation included line-by-line TDA proposals and recommendations on alignment of functions between the OTSG, MEDCOM headquarters, Health Service Support Area (HSSA) headquarters and medical treatment facilities. This formed the basis for all future discussions of the stratification of strategic, operational and tactical work levels among those organizations and became a keystone of the entire reorganization effort. Work levels are discussed in detail in paragraph III.C.

Two separate SME work group meetings were held, the second referred to as Fair Oaks II. Fair Oaks II focused on the AMEDD Center and School; Medical Research and Development Command (MRDC); and the concept of a Medical Service Support Activity as a place holder for several organizations that did not functionally fit into any other Major Subordinate Command (MSC). Again, detailed study books containing ODI analyses of these organizations were provided for all attendees. After this work group meeting, TFA met at Harper's Ferry, West Virginia, to develop a revised draft of the AMEDD organization. The draft consisted of the major organizational elements; critical underlying functions; and proposed staffing levels for OTSG, MEDCOM, and HSSA headquarters. All of this material was, in turn, provided to the OTSG Manpower division which subsequently produced the final AMEDD concept plan submitted to HQDA for CSA/SA approval (see Enclosure 6).

D. AMEDD Senior Executive Council (ASEC)

Throughout Phase I, TFA provided IPRs to the ASEC on study progress. The intent of these briefings was to keep the senior AMEDD leadership apprised of study direction, key underlying concepts, major points of contention and major decision points. For example, the original TFA proposal contained a recommendation to establish a new AMEDD organization focused on prevention and wellness issues. This proposal met with considerable resistance from some of the then senior AMEDD leadership. Nevertheless, TFA continued to present the concept to the ASEC as representative of what TFA interviews and briefings revealed the line customer base had been requesting. After integrating ASEC guidance into subsequent proposals, TFA gained formal ASEC approval of the prevention, health promotion and wellness concept, the precursor to the U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM).

From its inception the ASEC was not specifically chartered to be a decision making body. However, TSG preferred to have ASEC consensus on major issues before formal approval. This was another instance of stakeholder participation in the reorganization that paid later dividends. Thus, the ASEC proved to be instrumental in the overall restructuring effort. Accordingly, TFA presented update briefings to nearly all ASEC meetings conducted during the Task Force's tenure.

III. PHASE I OUTCOMES

A. ARSTAF and CSA Briefings

Concurrent with concept plan development, TFA coordinated and staffed the emerging concept with key ARSTAF principles. This coordination served two primary functions. First, as a normal part of staff work, it facilitated final approval of the plan. Perhaps more importantly, it was a continuation of the interview and stakeholder participation process at the senior Army leadership level. An example of one of these briefings (to the DCSPER) is contained at Enclosure 7. Each of these briefings provided stakeholder input into the concept plan and the final briefing to the combined ARSTAF principals, shown at Enclosure 8.

B. Concept Plan

Enclosure 6 contains the AMEDD's concept plan outlining the specific details pertaining to the establishment of the U.S. Army Medical Command (USAMEDCOM). Key features of that plan are listed below:

Falls Church, VA

1. OTSG ARSTAF downsized from 124 to 102 (later further reduced to 96).
2. U.S. Army Health Professional Support Agency (a FOA) inactivated with functions either eliminated or transferred to the OTSG ARSTAF; Headquarters, MEDCOM; or AMEDD Center and School.
3. U.S. Army Health Facility Planning Agency (an OTSG FOA)

redesignated as a subordinate activity within MEDCOM (later fully integrated into U.S. Army Medical Research and Materiel Command).

Fort Sam Houston, TX

4. USAHSC inactivated.
5. USAMEDCOM activated with TSG dual hatted as commander.
6. U.S. Army Dental Command (USADENCOM) activated as a major subordinate command of the MEDCOM.
7. U.S. Army Veterinary Command (USAVETCOM) activated as a MEDCOM major subordinate command.
8. AMEDD Center and School realigned as a MEDCOM major subordinate command and is scheduled to receive GME/GDE from Health Professional Support Agency.

Fort Detrick, MD

9. Combine U.S. Army Medical Research and Development Command with USAMMA into the U.S. Army Medical Materiel Command (later renamed to U.S. Army Medical Research and Materiel Command).

Tangible improvements fostered by this concept plan include establishing a single management framework, with TSG in command, which is responsible and accountable for the Army Medical mission. This single organization, with its streamlined command structure and clear lines of authority, is capable of effecting changes required for the transition of Army health care delivery to our beneficiaries as the nation continues to develop its framework for health care reform. It is also in line with recent DOD initiatives to centralize authority and responsibility for

the military medical mission within the Assistant Secretary of Defense for Health Affairs (ASD (HA)), with decentralized implementation by the military departments. In addition, significant medical migration to Ft. Sam Houston reduces the AMEDD force structure requirements in the NCR.

Specific intangible improvements include enhanced medical planning, programming and budgeting within the AMEDD by placing responsibility for these functions under one commander; improved planning, coordination, and integration on issues impacting on wartime readiness and peacetime health care; and clarification of responsibility and accountability for missions and functions within USAMEDCOM.

Overall improvements were to be verified by monitoring the management of a single, unified health management entity responsible and accountable for Army-wide health care delivery (including dental and veterinary services); organization and doctrine; medical research, development, acquisition, and logistics management; health promotion; preventive medicine; occupational health; and wellness. The organizational realignment was to result in some internal mission transfers, resulting in an AMEDD which is more accessible, deployable and accountable in an era of Army restructuring and right sizing.

C. Extant Structure

Extantly, the CSA has always held TSG accountable for the quality and timeliness of health care programs and services.

Unfortunately, TSG was never provided an effective structure for carrying out that accountability. CONUS-based health care fell under the operational control of HSC as the medical MACOM, but there was no AMEDD oversight of medical units assigned to FORSCOM. Further, overseas care was generally under the control of the appropriate CINC. Thus, it was difficult for TSG to wield effective influence over the entire medical community. As the AMEDD struggled to exercise a modicum of influence over its widely distributed assets, some overlap occurred between organizational roles at each of the various command levels. For example, OTSG staff perceived themselves to be accountable for overseeing all overseas activities because HSC did not have a worldwide mission. In effect, because of OTSG's proximity to the Pentagon, the staff commonly but improperly functioned as the medical MACOM, frequently displacing the former Health Services Command's proper role as the medical MACOM. The overlap was so pervasive that both OTSG and HSC were sometimes referred to as "halfcoms". This confusion blurred OTSG's manifest role in DA policy formation and HSC's role in strategic management. The result was duplication and redundancy at both sites.

Further confusion and conflict resulted from HSC's unwieldy span of control as it attempted to manage a total of 74 medical and dental facilities. HSC often exerted a degree of influence over these facilities in a manner that merged operational and tactical decision-making. Again, the result was frustration at both ends.

One of the primary objectives of the redesigned AMEDD was to reorganize the command around the following critical design principles:

- * Establish clear accountability and authority
- * Organize around work
- * Get people working on the right tasks at the right level
- * Eliminate duplication and redundancy
- * Value-added

In designing a requisite organization, the AMEDD's goal was to optimally align the major subordinate elements of Army Medicine to enhance overall readiness. Readiness gains were then to be closely followed by improvements in quality, access, and cost factors.

D. AMEDD Reorganization Objectives

The AMEDD identified three specific objectives on its path to reorganization. First, it was determined that the AMEDD would accept nothing less than a world class combat casualty care system. Very good or high quality was deemed insufficient assurance to the parents, spouses, children, and friends of soldiers that the Army intended to safeguard when they were deployed in harm's way. Second, accessible, high quality, and cost effective health care for soldiers, dependents, and authorized beneficiaries are required to meet the industry standard. Third, achieving a fully integrated AMEDD would

potentiate the seamless merger of deployed and sustaining base health care services. One AMEDD work force comprised of enlisted and commissioned soldiers; the civilian workforce; TOE and TDA units in the active and reserve components is required to span the settings formerly referred to as wartime and peacetime.

E. Design Principles, Mission, and Organizational Structures

One of the key design principles identified in the restructuring effort was to properly differentiate between different types of work (tasks). The intent was to clearly separate ARSTAF policy work from routine staff work and to differentiate between strategic, operational and tactical work levels. Figure 3 highlights the application of those principles to the AMEDD reorganization effort.

In the restructured AMEDD, OTSG now provides DA policy input in a genuine staff role as opposed to a pseudo-command relationship. This reorientation leaves HQ, USAMEDCOM free to address strategic management concerns. Health Service Support Areas (HSSAs) and their corresponding Dental and Veterinary (DSSAs and VSSAs) are now tasked with the operational responsibilities of managing their product lines on a regional basis. HSSAs, DSSAs and VSSAs represent a modernization and formalization of the former Health Services regional concept with an important distinction; there is now a regional network with the requisite command and control authority to coordinate

AMEDD REORGANIZATION PROPOSAL

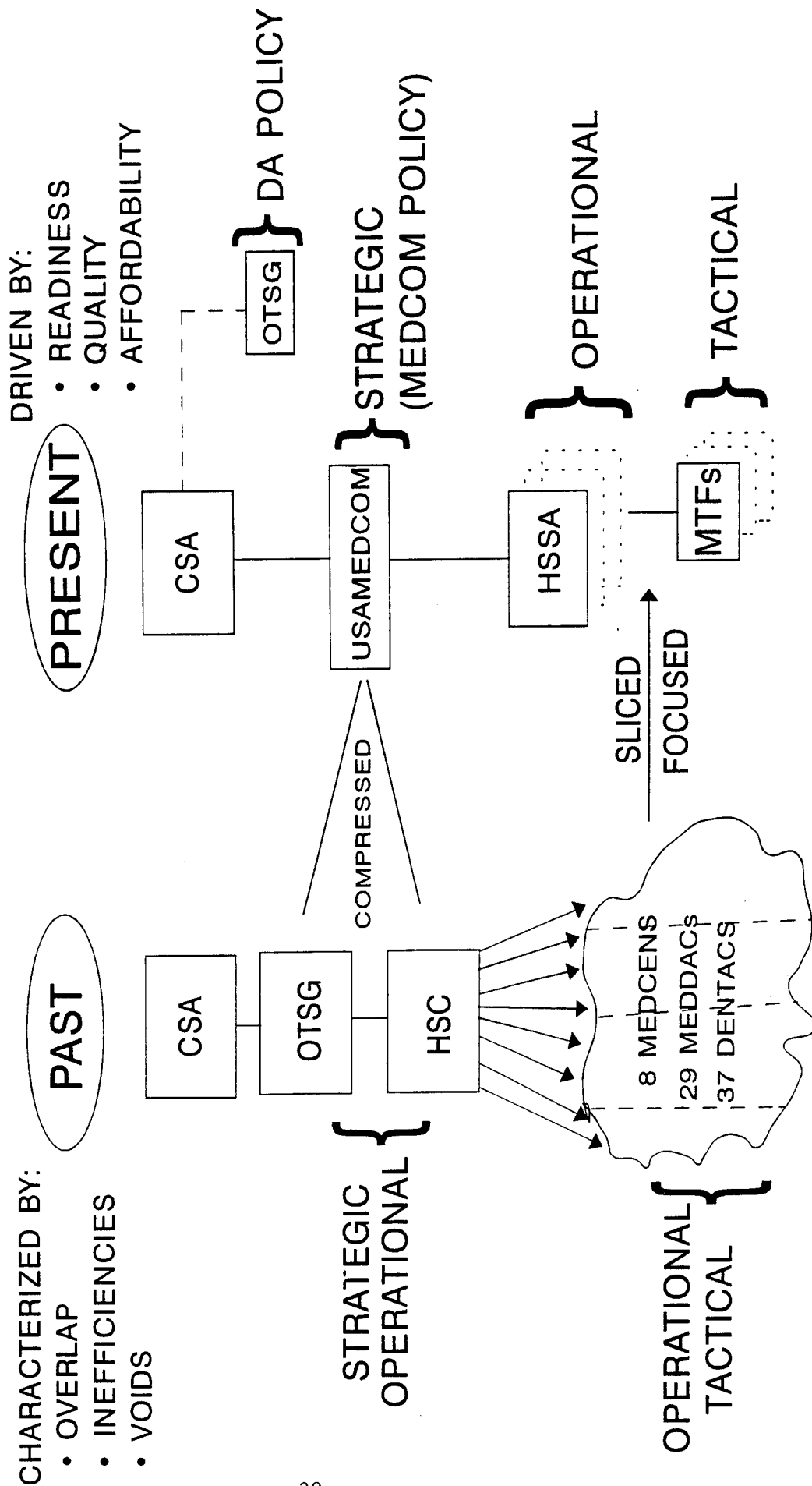


FIGURE 3

TASK FORCE AESCULAPIUS

services. Also depicted on Figure 3 is the elimination of the unacceptably cumbersome span of control with which HSC was saddled.

Having established the above guidelines for the overall reorganization effort, the AMEDD underwent a detailed organizational analysis process to first define and then refine each of the major layers in the requisite organization. OTSG and MEDCOM headquarters were analyzed twice to ensure proper alignment between their missions, design principles, and organizational structures. Each of the HSSAs and the MSCs were analyzed at least once; most were visited twice. The following sections highlights the major components of the new organization.

1. Office of The Surgeon General (OTSG)

The mission of OTSG is to assist the Chief of Staff of the Army (CSA) and the Secretary of the Army (SECARMY) in discharging their Title 10 responsibilities. OTSG achieves this mission by providing advice and assistance to CSA, SECARMY and other principal officials on all matters pertaining to the Army and the Military Health Service System (MHSS). Additionally, OTSG represents the Army to the Executive Branch, Congress, DoD agencies, and other organizations on all health policies affecting the Army. Finally, OTSG represents and promotes AMEDD resource requirements.

OTSG's organizational structure, see Figure 4, is now significantly smaller as a consequence of functions it formerly

PROPOSED OTSG ORGANIZATION*

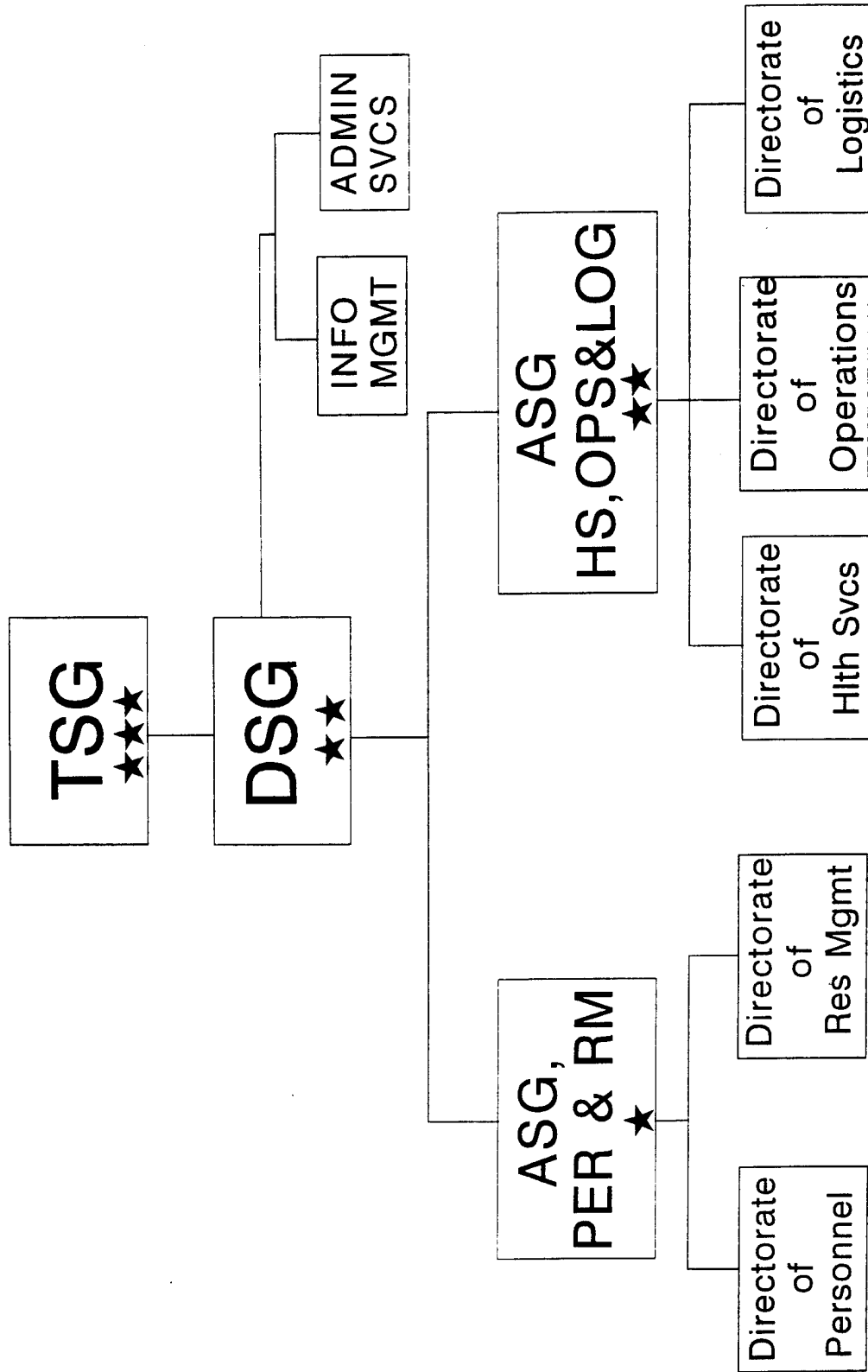


FIGURE 4

* AS MODIFIED BY OTSG
TRANSITION OFFICE

performed being either outright eliminated or transferred elsewhere. From an earlier, robust staff of greater than 500 personnel (including FOAs), OTSG will have fewer than 100 staff by the end FY 1997. OTSG staff is now distributed among five directorates overseen by the two Assistant Surgeons General (ASG). Both of those ASGs are dual or triple hatted with other senior AMEDD general officer functions.

2. USAMEDCOM HQ

The MEDCOM HQ mission is to provide vision, direction, and long range planning for the AMEDD. The MEDCOM headquarters develops and integrates doctrine, training, leader development, organization, and materiel for the Army health service system. In addition, the MEDCOM allocates resources, analyzes utilization, and assesses performance worldwide. Serving as the strategic center of AMEDD planning and operations, the MEDCOM employs a worldwide scope in focusing on strategic business planning. The MEDCOM enjoys the directive authority formerly but errantly ascribed to OTSG in making analytic assessments for continuous improvements across the command. The organizational structure employed to conduct the AMEDD's strategic business is depicted at Figure 5.

U.S. ARMY MEDICAL COMMAND

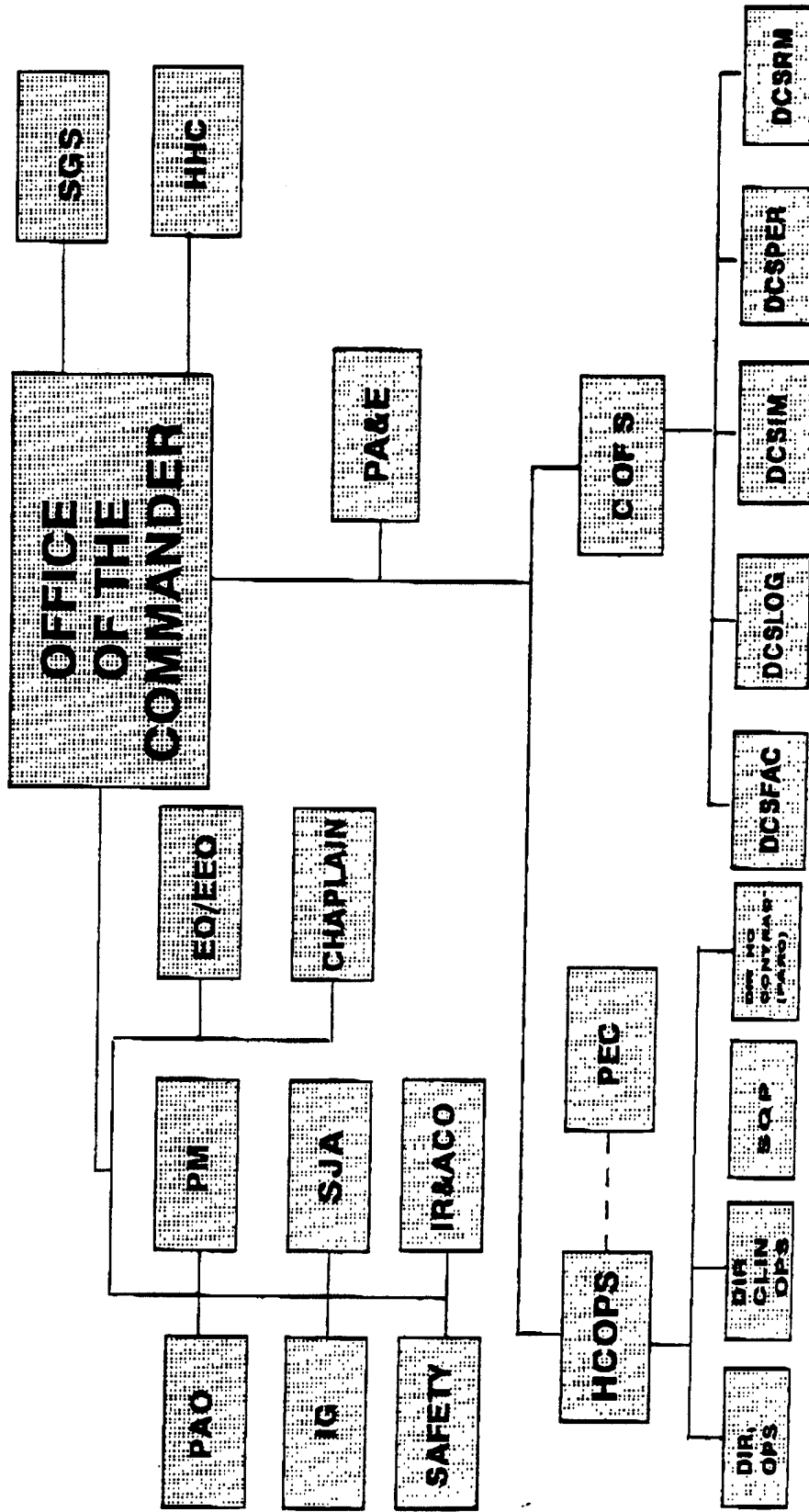


FIGURE 5

STRAT-49
AS OF:10-13-94

QUALITY

ACCESS

COST

MEDCOM also refers to relationships between USAMEDCOM HQ and its major subordinate commands (MSCs) as well as among the MSCs themselves, see Figure 6. Borrowing the Chief of Staff of the Army's Force XXI imagery, MEDCOM HQ occupies the center of a hexagonal relationship of the MSCs. As a full player in the Army's Force XXI concept (indeed, GEN Sullivan identified MEDCOM as the Army's first 21st Century MACOM) the MEDCOM depends on an increasingly fluid environment of partnerships necessitating more frequent and richer communication between its interrelated MSCs. MEDCOM HQ's rightful place in this alignment is where it can offer strategically significant input while fostering and monitoring the emerging partnerships. However, MEDCOM HQ cannot and should not impede the collaborative, team building efforts between its MSCs. It is significant and purposeful that the traditional depiction of a flat line hierarchical model was also depicted as a hexagonal figure to show the HQ relationship to the operational MSCs.

USAMEDCOM

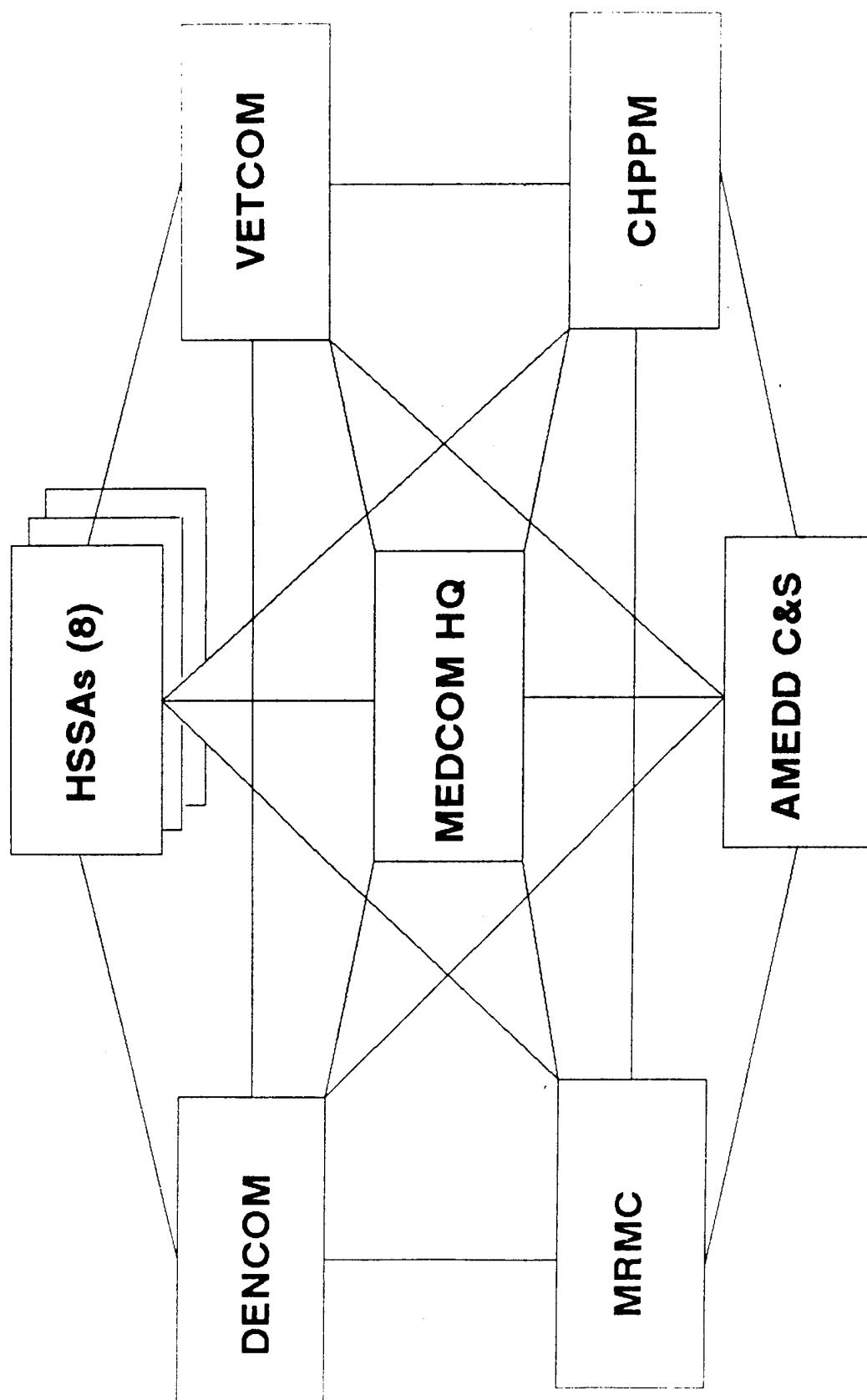


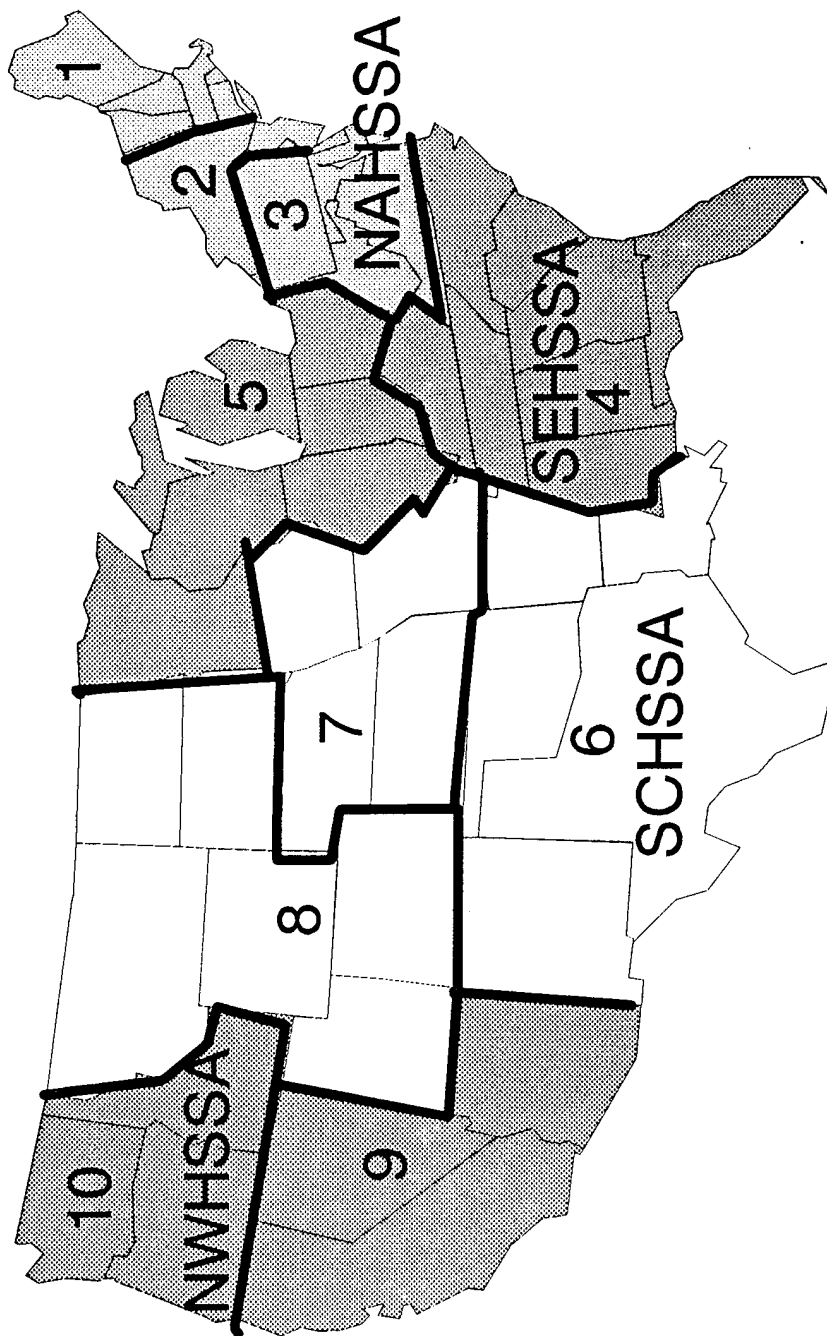
FIGURE 6

3. Health Services Support Areas (HSSAs)

The HSSA is the key structure around which MEDCOM supports the medical readiness requirements of America's Army. The HSSAs are an enhanced version of the former Health Services Regions. The most significant change is that HSSAs have regional command and control and are responsible to deliver an accessible, affordable, and cost effective health care system. HSSA commanders now are held accountable for merging the readiness, direct health care services (i.e., those organic to the MEDCOM's facility infrastructure), and indirect services (e.g. TRICARE, contract, and other arrangements) into one overall regional plan.

Crucial to the execution of enhanced medical readiness is the ability of the Active Component (AC) to partner with the Reserve Component (RC) medical assets. The 70% of AMEDD assets presently in the RC dictate an improved organizational alignment. A recent detailed Memorandum of Understanding with USARC formalizes the relationship between the AC and RC medical assets. An improved HSSA unit status reporting (USR) process further enhances the partnership by closely monitoring medical readiness of all deployable AC and RC Army units within the HSSAs. Specific emphasis is paid to the readiness of the medical units. The initial MEDCOM implementation plan which included options of between four and eight HSSAs. At the time of this writing there were four CONUS and two OCONUS HSSAs, see Figure 7. The basis of alignment in CONUS is the USAR's Regional Support Command (RSC) network newly created from the obsolete Army Reserve Command

MEDCOM XXI--RC READINESS REGIONAL SUPPORT COMMAND/GROUPS WITH PROPOSED HSSAs



NOTES: a) Western boundary of SEHSSA is also the boundary between the CONUSAs.

b) ARCOM geographic/state boundaries coincide with HSSA boundaries.

FIGURE 7

HSSA REDESIGN-29 MAR 95-MAJ RAY HORN

(ARCOM) structure. The ten RSCs are distributed among the four HSSAs in CONUS creating a simpler coordinating alignment between the AC and the RC.

AMEDD REORGANIZATION
PHASE II: IMPLEMENTATION

IV. IMPLEMENTATION

Submission of the AMEDD reorganization Concept Plan to the Deputy Chief of Staff of the Army for Operations (DSCOPS) on 16 July 1993 was a major milestone in the reorganization effort. However, many people advised that the hard work of approval and implementation was still ahead. This could not have proven to be more prophetic. The next two years was spent in obtaining formal approval of the Concept Plan; monitoring the restructuring of staffs and redistribution of work at OTSG and the MEDCOM; assisting the development of the HSSA concept; evaluating and developing the other major subordinate commands of the MEDCOM; marketing the reorganized AMEDD; and advising, monitoring or assisting on a number of issues related to the reorganization. As with the initiation of the reorganization project, TFA developed a charter with TSG to chart the course for Phase II work. A copy of the charter and a list of the Phase II Task Force members is at Enclosure 9.

A. Concept Plan Approval

DCSOPS did not formally approve the MEDCOM Concept Plan until 24 February 1994, seven months after its submission. This delay was primarily due to the requirement to establish a clear audit trail of all personnel authorizations affected by the

reorganization. Tacit approval for establishing a MEDCOM was received from the Army leadership almost simultaneous to submitting the plan. This was due primarily to two factors. First, the ARSTAF, other Army leaders (e.g., MACOM Commanders) and special interest groups were kept informed throughout the initial reorganization period via a series of formal and informal briefings and negotiations by TFA, ODI and the OTSG Manpower Division. By the time the concept was briefed to GEN Sullivan on 23 June 1993 and to the assembled ARSTAF principals on 08 July 1993, approval was virtually assured. Second, the OTSG Manpower Division applied a tremendous wealth of historical knowledge related to concept plans to the current effort. Their most recent experience with submitting a similar Concept Plan in December 1992 placed them in an excellent position to facilitate acceptance of the 16 July effort. While formal approval was an important and necessary step, implementation was allowed to proceed as planned with the U.S. Army Medical Command (Provisional) being established on 1 October 1993.

B. OTSG/MEDCOM Restructuring and Interface

The U.S. Army Medical Command (USAMEDCOM) was provisionally established on 1 October 1993 and fully activated on 2 October 1994. Intensive coordination between the OTSG and HSC (subsequently MEDCOM [Prov]) staffs actually began prior to October 1993 and continues to move toward TSG's vision of a seamless staff between Washington and San Antonio. To facilitate

the transition process, every available means of communication was used. However, the primary vehicle was a series of combined staff video teleconferences (VTCs) to review functional transfer between OTSG and the MEDCOM and further functional transfer to the Health Service Support Areas. The work of these meetings was the responsibility of the respective staffs with oversight by the Chiefs of Staff. TFA and ODI were responsible for monitoring and advising during the process. While most functional transfers were worked out on paper, actual transfer of work met with variable success.

With major shifts of functional responsibilities, shifts in personnel requirements obviously follow. Reviews of the reorganization process indicate that numbers of authorized and assigned personnel are changing in accordance with established schedules. One of TSG's directives was that personnel turbulence would be minimized in all activities. This directive has been followed meticulously and has greatly facilitated acceptance of the reorganization process. Regarding personnel, OTSG was the most dramatically affected activity in the AMEDD. Consequently, within OTSG a full time, temporary office was established to assist in personnel transfers and reassignments. This effort have been superb to date.

Functional reevaluations of both OTSG and the MEDCOM were programmed requirements of TFA and ODI. The relook of TSG's staff indicated that much progress had been made since the original analysis. Unresolved issues pertaining to the offices

of the Assistant Corps Chiefs, and GME had been provisionally resolved. Some internal adjustments regarding support staff were being renegotiated. Two lingering issues remained. The first was related to a lack of clarity between the role of TSG Health Care Operations vis-a-vis the MEDCOM Clinical Operations Directorate. The underlying issue revolved around who was perceived to be in charge; OTSG or the MEDCOM. This issue was exacerbated by the fact that OTSG had a Major General assigned to Health Care Operations whereas the MEDCOM had a BG. Nevertheless, this problem is likely to be resolved in the near future. The second issue facing OTSG concerned a propensity to continue to assign required support staff on other National Capital Region TDAs. Rather than confront the issue head on, it appeared that compromises continue to be made. Even these compromises, however, will eventually migrate to a suitable resolution.

The MEDCOM relook suffered from the fact that even though the command had operated in a provisional status for a year, true change did not move into full speed until the full activation of USAMEDCOM on 4 October 1994. Thus, at the time of the reevaluation, it was premature to thoroughly analyze the nature and extent of change existent within the MEDCOM. Time constraints precluded further delay of the reevaluation. Therefore, data collection and analysis was specifically oriented, to the extent possible, toward projected end-state work.

Three major issues were unresolved. The first was documentation of approximately 30 positions transferred out of OTSG but never documented on the MEDCOM TDA; e.g., the Claims Consultation Review Board. At the time of the reevaluation, these positions were undocumented although they constitute necessary MEDCOM business. The second issue had to do with transferring existing operational assets from the MEDCOM to the AMEDD C&S; e.g., the manpower modeling division and GME. Finally, the roles and relationships of existing MEDCOM FOAs is unresolved; i.e., Health Care Systems Support Activity (HCSSA) and the MEDCOM Acquisition Activity. Currently these are not aligned in accord with long-term MEDCOM plans.

At the request of the MEDCOM and as an augmentation to the information management task force, a separate analysis of HCSSA was conducted. A detailed report of the analysis is contained at Enclosure 10. HCSSA represents a MEDCOM FOA dedicated to providing a variety of information management support functions to the AMEDD. Most of the support it provides is necessary and essential to the effective functions of the AMEDD. However, some support, or the management thereof, is of questionable value. So long as HCSSA receives programmed funding, such support is not likely to be as fully scrutinized as if the customer had to pay for that support. Final resolution of HCSSA's organizational structure should be held in abeyance until the information task force (Task Force Mercury) completes its work.

C. HSSA Development

As described previously, a major design feature of the restructured MEDCOM was the creation of HSSAs. The HSSAs were to manage health care throughout a specified regional area to include enhancing the overall readiness of all RC units within that same geographic area. Some HSSAs were also designated as Lead Agents and some were not. Lead Agency was a concept developed by ASD(HA) to provide a single managed care support contract in a specified regional area. Under these contracts, a civilian health care provider will supplement existing DoD health care services available in that region. The original intent was that lead agency would augment existing military health care not supplant it. Local MEDCEN and MEDDAC commanders were to utilize contracted support whenever and wherever it made good business sense. (A thorough discussion of lead agency is beyond the scope of this report). Because lead agency involved developing and awarding a substantial government contract in a very compressed time, it assumed a sense of urgency and tended to dwarf other HSSA business.

Perhaps, the single greatest shortfall in the entire AMEDD restructuring effort is an ongoing inability of the Command to establish viable HSSA organizations. Several reasons underscore this observation. First, dedicated staff was rarely allocated to the HSSAs. Some staff are currently being assigned but they represent "out-of-hide" MTF assets or RC personnel. Second, some HSSA command groups never really endorsed the concept.

Similarly, some on the MEDCOM headquarters staff fought the idea of downloading autonomy to the HSSAs. Third, lead agency consumed the attention of several HSSAs. Fourth, too many HSSAs evolved. Finally, OASD(HA) and the other military services seemed to resent the presence of HSSAs even though they predated lead agency.

Collectively, the above issues combined to thwart full scale development of HSSAs. Nevertheless, some progress is being made. At the time of this writing, six CONUS HSSAs have been collapsed into four; the Euro HSSA has been decoupled from the theater MEDCEN; dedicated HSSA staff members are now being assigned; and one HSSA is actively contemplating realigning its headquarters structure with the supported corps. Lead agent contracts have been awarded in several HSSA areas. Fiscal resources have been down loaded from the MEDCOM to the HSSA organization. These are all positive developments and should signal a real change. What has not happened yet is any significant improvement in readiness support, although there are positive signs in this regard. The fact is that HSSA maturity is probably still at least one year away.

D. Other Major Subordinate Command Analysis

An important element of Phase II was a detailed assessment of each of the MEDCOM's major subordinate commands. The results of these analyses are presented below.

1. Medical Research and Materiel Command (MRMC)

MRMC was formerly known as the Medical Research and Development Command (MRDC). Historically, MRDC enjoyed a special relationship with the Assistant Secretary of Army for Research, Development and Acquisition (SARDA). In fact, because SARDA provided research funds (P-6), MRDC tended to respond more to SARDA policy initiatives than to OTSG initiatives. Over the years, MRDC became quite adept at deftly maneuvering between the two funding sources, SARDA for P-6 funds and OTSG for P-8 funds. When it was convenient to adhere to OTSG directives, MRDC did so. Alternatively, however, when SARDA directives were perceived to be more in concert with MRDC goals, they become the governing factor.

This situation changed dramatically with the restructuring of the AMEDD. First, several OTSG FOAs were realigned under MRMC; i.e., Health Facilities Planning Agency (HFPA) and U.S. Army Medical Materiel Agency (USAMMA). It was decided that all operational logistics efforts would be centralized under MRMC; hence the addition of the material name to MRMC. A preliminary analysis of MRMC was conducted in 1993. Results of this study are contained in Enclosure 11. A second, more comprehensive analysis was conducted in May/June of 1995 (Enclosure 12). While some of the recommendations contained in these two analyses were in fact implemented, many were put on hold pending the final outcome of the impacts caused by the initiation of the Medical Research, Development and Acquisition - 21 (MED RDA-21) Project,

a DoD-wide project exploring the feasibility of consolidating all Defense medical R&D assets. MED RDA-21 was subsequently renamed the Medical R&D Consolidation Project. The full effects of this project have yet to be determined or evaluated. However, one of the stated goals of the project is the implementation of an Armed Forces Medical Research & Development Agency (AFMRDA). This has the potential of completely reshaping the organizational structure, command and control of MRMC. An AFMRDA has the full support of the Defense Director for Research and Engineering (DDRE) and the Assistant Secretary of Defense for Health Affairs (ASD(HA)).

2. AMEDD Center & School

Two separate analyses of the AMEDD C&S were conducted (similar to MRMC). The results of these independent efforts are contained in Enclosures 13 and 14. The first analysis identified a number of specific changes and was received with mixed results. While this TFA-sponsored study was being conducted, a separate internal reengineering effort was also underway. Both studies generated a number of specific recommendations. When such recommendations were congruent, the AMEDD C&S implemented them as stated. When the two sets of recommendations differed the C&S tended to implement their own study conclusions. Nevertheless, many good changes were effected by the combined output of both studies.

The second, more in-depth analysis of the C&S was conducted

in the summer of 1994. This study produced a number of sweeping recommendations (see Enclosure 13). Many of these recommendations have been implemented and some are still being analyzed. Perhaps, the most significant change to affect the AMEDD C&S is the decision to make Fort Sam Houston an AMEDD installation and to organize it in accord with other TRADOC installations. In other words, the Commander, AMEDD Center & School is also to be the installation commander. With the concurrent move throughout the Army of establishing mega-installations, this is a significant new mission for the AMEDD.

Another significant change affecting the AMEDD C&S is the decision to transfer (and consolidate) the offices of the Assistant Corps Chiefs. This change clearly establishes the C&S as the home of branch and personnel proponency. Perhaps no other issue has generated as much discussion and interest as consolidating the day-to-day corps chief function in San Antonio at the AMEDD C&S. Over the long haul, however, this move should prove most beneficial.

3. New Commands

A central design goal of the overall AMEDD restructuring effort was a desire to separate operational work from staff work. Further, since AMEDD operational work covered a wide spectrum of products and services, e.g. health care; research and development activities; training and education; dental care etc., it was also decided to differentiate

operational work by product line. Managing these concerns led to the formal establishment of three new commands within the MEDCOM: U.S. Army Dental Command (DENCOM), U.S. Army Veterinary Command (VETCOM), and U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM). The products and services delivered by each of these new commands were considered separate and distinct product lines.

The decision to establish separate commands to oversee these product lines was not universally accepted initially throughout the AMEDD. Some senior ASEC members insisted that they should be a part of each HSSA since all three share a unique symbiotic relationship with their local MEDDAC/MEDCEN. Resistance to creating a separate prevention and health promotion activity was particularly high because several ASEC members believed that prevention issues were already being adequately addressed by organic preventive medicine assets within the MEDDAC/MEDCEN structure. The final decision to organize around product lines was heavily influenced by customer comments from a number of senior Army leaders (e.g., CINCs). For example, several CINCs reported that, in their opinion, the quality of dental care was outstanding and the dental care system should be essentially left unchanged. Such comments strongly reinforced the TFA desire to establish separate stand-alone commands for Dental, Veterinary and Health Promotion/Prevention Services. Each of these separate commands were subsequently analyzed as part of phase II; these analyses are described below:

a. U.S. Army Dental Command

The U.S. Army Dental Command (DENCOM) was activated as a major subordinate command of the MEDCOM on 14 November 1994. The formal establishment of DENCOM as a separate command represented the final step in an evolutionary process that recognized dental care as a separate product line within the medical community.

The DENCOM HQ organization was established from the previous staff assigned to the HSC Director of Dental Services. The creation of the DENCOM did not require any additional personnel to be assigned to the command's headquarters. To oversee the 31 DENTACS and approximately 172 clinics operating throughout the world, eight Dental Service Support Areas were created. These intermediate headquarters corresponded to the eight Health Service Support Areas (HSSAs), which were also designed to oversee regional health care. Each DSSA was staffed by dual-hatting existing DENTAC staff personnel and by assigning one additional support staff to the headquarters. Each DSSA, in turn, was accountable for overseeing the activities of a number of DENTACS and subordinate clinic commands and clinics located within a given regional boundary.

An in-depth analysis of the activity was conducted in March/April 1995 (see Enclosure 15). The primary conclusion of this analysis was that the Command is functioning effectively and continuing to deliver "world class" dental services to its customer base.

Nevertheless, several troublesome issues confronted the DENCOM. First, basic recruiting problems were creating some undesirable second order consequences. Because of a shortage of junior dental corps officers, most clinic commands were commanded by colonels instead of lieutenant colonels. While this strategy solves short-range problems, it unfortunately undermines long-term leader development efforts. Use of area dental labs (ADLs) was also identified as problematic. Frequently, some DENTACs preferred to use internal organic laboratory capabilities instead of the ADLs, even though there was a substantial cost differentiation between the two. This latter finding, however, is currently being resolved by the DENCOM command group.

b. U.S. Army Veterinary Command

The U.S. Army Veterinary Command (VETCOM) activated as a major subordinate command of the MEDCOM on 15 November 1994. The command was organized to reflect the unique product line of veterinary services (versus medical and dental), enhance readiness, and ensure an overall capability of providing high quality accessible veterinary services throughout DoD. The Army Veterinary Service has served as the DoD Executive Agent for Veterinary Services since 1981. As a result of that expanded mission and in accord with lessons learned from Operations Desert Shield/Desert Storm, the Veterinary Service Directorate strengthened an existing, albeit weak, regionalization concept. The VETCOM VSSAs formalize the regional organization and provide

the flexibility needed to meet the requirements imposed by numerous DoD mission deployments, changes in operational missions and in research and development programs. Regionalization allows the VSSAs to reconcile personnel imbalances within large areas of responsibility. The VETCOM structure also improves the readiness of the AMEDD through shortened chains of command, increased coordination in joint training efforts with TOE and RC units, and effective personnel movements during mobilization.

The VETCOM headquarters was established from the staff assigned to HSC, Directorate of Veterinary Services with no additional personnel assigned to the new headquarters. To oversee the existing veterinary districts and corresponding branches, 7 Veterinary Service Support Areas were created. These headquarters corresponded to 7 of the Health Services Support Activities (HSSAs). European operations were treated separately. Each VSSA was accountable for overseeing the activities of a number of districts and subordinate branches located within their respective regional boundaries.

A comprehensive analysis of the VETCOM was conducted in March/April 1995 (see Enclosure 16). The primary conclusion of that analysis was that the VETCOM organization was effectively carrying out all DoD assigned missions. One issue was identified as problematic. That issue pertained to the absence of a European VSSA which resulted in all theater oriented veterinary assets being assigned to the warfighting corps (5th corps). The impact of being a corps TOE asset was reportedly beginning to

undermine the ability of some TDA veterinary assets to perform their theater mission. The original rationale for placing all veterinary assets into the corps was understandable. Nevertheless, the command climate had changed sufficiently that the issue needed to be resurfaced. A final decision on the creation of a European VSSA is due in the summer of 1995.

c. U.S. Army Center for Health Promotion and Prevention Medicine

The U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) constitutes a new command within the overall MEDCOM organizational structure. The command itself was built around the basic chassis of the existing Army Environmental Hygiene Agency (AEHA). However, USACHPPM was designed to be a much more encompassing command than AEHA. First, the basic mission of the organization was significantly altered. Several new program areas were added; i.e., health promotion and wellness; preventive medicine; and epidemiology and disease surveillance. Second, the command was aligned as a separate major subordinate command of the MEDCOM and not as a field operating activity of OTSG. Third, a general officer was assigned as commander to reflect the appropriate level of authority for the command and to enhance managerial oversight for program development and execution. Fourth, the command assumed responsibility for subordinate elements worldwide, e.g. USAPACEHA in Japan and the former 10th Med Lab in Europe (redesignated to

USACHPPM-Europe).

An in-depth analysis of the USACHPPM organization was conducted in April/May 1995. Results of this analyses are contained in Enclosure 17. A major finding of this analysis was that USACHPPM is struggling in its attempt to fully integrate new mission areas. Currently, CHPPM does not receive sufficient core (program) funding from MEDCOM to provide the full range of services requested by the existing customer base.

The addition of new mission and program areas exacerbates this funding shortfall. Thus, a significant challenge facing the Command is how to prioritize existing resources (personnel and dollars) in order to develop all their new programs. Another major challenge facing the command is how best to employ the Direct Support Activities (DSAs). Should they redirect their support efforts more to the RC or continue to provide general support services to Active Component installations within their respective geographical areas? With the BRAC approved decision for Fitzsimons Army Medical Center to close, should DSA-west also be closed or moved to another more central location? These issues along with a set of accompanying recommendations are described in Enclosure 17.

Despite the above described unresolved problems and issues, the real significance of this discussion is that USACHPPM was formally established as a separate major subordinate command of the MEDCOM. This separation of preventive medicine, health promotion and wellness programs from other health care services

is indeed a significant first step in enhancing their overall stature within the health care community. Remaining problem areas can then be addressed, as appropriate.

E. Marketing the Reorganization

The importance of marketing the reorganization cannot be overstated. TFA spearheaded the effort to manage more actively a widely diverse group of stakeholders, both internal and external. LTG LaNoue commonly refers to himself as the chief marketer for the AMEDD. However, the Army Medicine reorganization has demonstrated that genuine marketing, in its broadest sense, must be diffuse and pervasive throughout the organization.

Marketing the AMEDD begins with knowing how and when to differentiate between the AMEDD and USAMEDCOM, for example, and between the Surgeon General and the MEDCOM commander. TFA has found it effective to remind its audiences that AMEDD is the most inclusive term, encompassing all AC and RC as well as TOE and TDA medical assets. AMEDD also includes all eight corps of medical personnel: Medical, Dental, Nurse, Veterinarian, Medical Service, Medical Specialist, Enlisted, and Civilian corps. Conversely, USAMEDCOM must be recognized as the cluster of active duty major subordinate commands. While USAMEDCOM implies inclusion of the Fort Sam Houston corporate headquarters, references to USAMEDCOM or MEDCOM frequently address the headquarters exclusively.

Such terminology clarity is important when addressing any element of the AMEDD's stakeholder network. A brief list of

internal stakeholders includes USAMEDCOM's MSCs, medical personnel assigned to AC and RC, TOE and TDA units, and the eight personnel corps listed above. Obviously these subgroups are not completely separate; Army Medical personnel may be listed and sorted into several groups at once. What is important is to be cognizant of the multiple perspectives one AMEDD soldier may have.

TFA has also learned that the external stakeholder community likewise depends on clear terminology in communication. A short list of external stakeholders would include, but not be limited to, the Chief of Staff of the Army and his staff, Army MACOM commanders, Commanders in Chief of joint and combined commands, Health Affairs, the military coalition, Congress, and the American people. While internal stakeholders may err in assuming they know too much about Army Medicine, we must protect the external stakeholders' interests by not assuming anything about what they understand about the AMEDD, especially as reorganized.

Issues of marketing the reorganization, terminology clarification, and stakeholder identification, have always been significant - even when not formally acknowledged. However, as TFA changed its focus from an initial role in concept development to a subsequent one in reorganization implementation, these issues took on even greater importance.

The basis for the change in TFA's focus, and thus how it marketed its product, was the charter for each phase. The specified mission for TFA's initial phase was to recommend, "...

alignment of the mission, functions, and structure of the AMEDD to support its strategic vision ..." The specified mission for TFA II was "... to promote and actively monitor the implementation of the newly designed MEDCOM ..." The defining event separating the two phases was the acceptance, with modification, of the AMEDD reorganization concept plan by DCSOPS.

The two key tasks for TFA II were to field the reorganized AMEDD and to conduct a second stage analysis of the MSCs: HSSAs, DENCOM, VETCOM, AMEDD C&S, MRMC and CHPPM. First, since the concept development for restructuring Army Medicine took place mainly at a senior level among internal and external stakeholders, there was a lot of work to be done, primarily in education. Second, each of the MSCs were either brand new commands; e.g., CHPPM, or were significantly changed; e.g., MRMC, to warrant reevaluating their alignment of missions with organizational structure.

There was a common observation among TFA II members pursuing both tasks: when dealing with personnel lower than senior command groups in the MSCs, virtually no one was familiar with either the rationale for or the process of reorganizing the AMEDD. In direct counterpoint to LTG LaNoue's recurrent emphasis on systems thinking, virtually none of the MSCs communicated an understanding of their internal alignment of mission and structure. Even more rare was an MSC element that could link all of the MSCs into one integrated corporate entity.

An AMEDD Marketing Process Action Team (PAT) convened to

develop a corporate-wide marketing awareness. Lead by BG Adams, as the ASG for RM and PER, the PAT included representatives from all 13 USAMEDCOM MSCs, USAR and National Guard, USAREC, and OTSG. Coincidentally, and prior to the PAT's first meeting, an AMEDD Strategic Planning Conference convened and identified marketing as one of the AMEDD's five key strategies. One of the PAT's intended purposes was to create a distributed network of subject matter experts for marketing the AMEDD, serving both their MSC commanders and the AMEDD at-large. Evidence from PAT members suggested their commanders complied but were not enthusiastic. The PAT's main contribution was to provide focus group feedback about how the AMEDD might more effectively pursue marketing and the consensus view was that professional, commercial input was required. The PAT acknowledged that the competitive health care business environment dictated professional marketing consultation

The enduring lesson learned from the AMEDD's efforts to market both the process of restructuring and the reorganized AMEDD as an end-state organization, was that the timeline for achieving genuine change was longer than anticipated. GEN (R) Thurman opined such a change as the AMEDD was undergoing requires 3-5 years to complete. Viewed initially as a tactic by which to transform the AMEDD from what it used to be into the requisite organization that could realize LTG LaNoue's vision, the AMEDD reorganization began to be recognized as strategic marketing. The process clearly required the long view and, indeed, the reorganization neatly fit the 4-stage marketing process as

defined by the AMEDD Marketing PAT:

1. Identify stakeholders, internal and external.
2. Identify their needs, wants, and expectations (N,W,Es)
3. Reorganize to meet or deliver N,W,Es.
4. Communicate steps 1-3 and revalidate.

As of this writing, the time is at hand to pass the stewardship for marketing the AMEDD from TFA II to USAMEDCOM's Strategic Planning office (SPO). The SPO office has been redesigned as a result of TFA II's second stage analysis of USAMEDCOM headquarters. That analysis indicated SPO was not functioning in a long term (5-10 year) strategic time frame. Thus, there was effectively no strategic vision employed at the manifest strategic plane within the AMEDD.

To correct this strategic deficit, the requisite SPO at USAMEDCOM will employ three integrated functions. First is visioning. Acknowledging the AMEDD is part of a fiercely competitive health care business environment, it is incumbent upon USAMEDCOM to look into the future, in an unconstrained view, at what health care at-large will look like 5-10 years from now. The second function in SPO, marketing, will insert the constraints of reality and employ the four step process outlined above to shape the AMEDD. The third SPO function, transitioning, will manage the perpetual change of getting from where we are to where we need to be. Frequently TFA II has been told that if SPO were executing these functions in the past, we would not have required so extensive a reorganization in the present. The

intent is to proactively prevent such a disruption in the future.

F. Related Issues

There were a number of issues that, to some degree, related to the AMEDD reorganization. The relationship varied from tangential to intimate. Regardless of the degree of relationship these issues consumed large quantities of time and energy on the part of the Task Force and impacted various facets of the reorganization effort. A brief review of these issues illustrates their part in the reorganization.

1. Information Management Study

Early during the reorganization process, it was recognized that AMEDD's information management (IM) was in need of a major overhaul. Without an effective and efficient IM program, no amount of reorganization can develop a world class health care organization. At the 15 June 1994 ASEC, TFA recommended that a formal study of IM be conducted with a suggested time frame of 01 Oct 93 - 30 Sep 94. The proposed goal of the study was to integrate AMEDD IM assets for best support of planners and decision makers. This recommendation was approved by the ASEC and the study was initiated in October 1993. The Chief, Information Management at OTSG was appointed as the study sponsor. A study directive was published on 04 November 1994 and a detailed study plan followed on 07 February 1994. Major problems identified by the study group were as follows:

1. No strategic vision
2. Inconsistent organizational structure
3. Inadequate IM personnel development program
4. Poor customer feedback loops
5. Poor accessibility and usability of available data

One of the first accomplishments of the IM project was the designation of the first ever AMEDD Chief Information Officer (CIO), an essential position in any successful large corporation. The CIO's office was established with an intentional strong emphasis on client membership.

Concurrent with this action, the study team employed a private contractor to assist in their process. The contractor utilized a program called Structural Cybernetics (SC) as the chassis for his assistance. SC succeeded in getting the AMEDD's IM leadership to begin using a structured analytical process, designed specifically for IM enterprises, to identify their strengths and weaknesses. Most importantly, it established the necessity for customer interface and consultancy as absolutely essential for a successful IM program. With this frame of reference, the newly established Information Resource Management Executive Committee (IRMEC), along with the Office of the CIO, proceeded toward the goal of developing an AMEDD IM Strategic Plan.

The first year of the IM project was considered as only marginally successful by many for a number of reasons. First, the project took too long to get organized. An IM Strategic Plan

was not developed. Talented consultants who understood both health care and IM technology could not be developed or recruited quickly enough. There was no dedicated General Officer assistance and oversight of the project. There was considerable personnel turnover within the AMEDD IM senior leadership. Client and AMEDD leadership expectations were probably too high. And, there was a lack of marketing of the project; i.e., the customer base was not kept adequately informed. Despite all these obstacles considerable progress was made toward identifying and initiating repairs on many problems that had exacerbated themselves during the past several years of explosive progress in the world of information technology. A firm foundation was laid on which the General Officer led Task Force Mercury could build a sound IM program for the new AMEDD. This Task Force continues its work and remains a cornerstone to the overall reorganization project.

2. Graduate Medical Education and Force Modeling

GME is a cornerstone of Army medicine. The TSG has been steadfast in his conviction that GME is critical to the maintenance of quality health care. According to the TSG, the standards, scope of practice, and professionalism required by the teaching program accreditation organizations and supporting clinical investigations, directly contribute to the high quality of health care prevalent in the Army. Army programs have, during the last forty years, repeatedly demonstrated their excellence

through the almost 100% accreditation rate; the success of their trainees and graduates in both in-service and board examinations; and the distinguished careers to alumni both in and out of the service. Viable GME Programs are viewed as key to the retention of quality physicians and to the survival of nationally recognized medical assets such as the Army Burn Center.

Despite widespread accolades associated with the existing GME programs, it continues to be attacked by opponents, both inside and outside the military. External critics often challenge the cost of GME, arguing that civilian run programs are more cost effective. Even though assessing the true cost of GME is a tortuous endeavor, several studies published by the military services conclude that GME in the civilian sector is more expensive. ASD(HA) recently published a plan to downsize and combine GME programs across all three services. The main problem with this proposed plan is that it does not adequately reflect any force structure considerations.

In response to the above pressures, the Task Force recommended a thorough review of the current AMEDD force modeling process. It was quickly recognized that this was a large, long-term project outside the scope of TFA work. Consequently, after initial concept development work the AMEDD contracted with Vector Research, Incorporated (VRI) to thoroughly analyze the Army's physician requirements considering both deploying force and sustaining base mission needs. TFA personnel developed the Statement of Work and other contract requirements and have served

as the Contracting Officer's Technical Representative for the contract since its inception.

The rationale behind selecting an external contractor included enhancing overall credibility of published results. It was felt that if internal AMEDD assets were to conduct such a study, the results would lack sufficient credibility as to seriously undermine any relevant conclusions. Past internal studies were essentially dismissed as parochial and invalid. VRI was chosen in part because they have an extensive background in analyzing force structure issues for other elements of the Army and they have an established track record of credibility with Army and DoD leadership. Additionally, it was recognized that pressures to reduce GME would be prevalent throughout the remainder of the decade. A hallmark of VRI's force modeling products is ease of adaptability over time to changing scenarios, making them suitable for use for an extended time period.

A second key issue related to GME was the desire to relocate the program administration from the NCR to Fort Sam Houston. Few issues in the overall reorganization effort generated as much emotion and high level interest as this topic did. Dire predictions were made if the program were to be moved. It was argued that day-to-day management required extensive interactions within the NCR. Further, key personnel were reportedly not going to move, thereby seriously jeopardizing the efficiency of the whole program. The original proposal was to move the program to the AMEDD Center and School. After much discussion and emotional

catharsis, it was decided to move the program to the MEDCOM (not the Center and School) in two different stages, the first part moving in 1995 and the remainder moving in 1997.

Currently, the GME program is functioning as a split based operation under the auspices of the MC corps chief who is dual-hatted as the Director of Clinical Operations in the MEDCOM Headquarters.

3. Corps Chiefs

An important element in the AMEDD reorganization plan was the decision to relocate the individual Corps Chiefs from the National Capital Region to San Antonio (Ft. Sam Houston). Perhaps no single issue in the entire reorganization proved to be as difficult to accomplish as this. The emotion and energy surrounding the Corps Chief issue (including the related issue of the office of the Assistant Corps Chief) was without parallel. Over the years the role of the Corps Chief evolved into a prestigious and powerful position, yet one that continues to be widely misunderstood (see Tab D to Enclosure 14). Corps Chiefs functioned not only as the branch proponent of their respective corps; but also as the talent pool manager for all key personnel and as a mentor of select individuals. Corps Chiefs also represented their respective corps to a variety of external accrediting and/or professional organizations.

All of these tasks constitute important and necessary work. However, problems arose when the AMEDD uncoupled general officer

roles from Corps Chief roles. Prior to this, each Corps Chief was the senior officer in a given Corps. Some Corps Chiefs were general officers and some were not. As the Army downsized, the number of general officers also went down. These declining numbers made it more and more difficult for the AMEDD to retain general officers solely as Corps Chiefs. It was finally decided that all general officers would be assigned to general officer equivalent roles and dual hatted as their respective Corps Chief. This change necessitated the concurrent recognition that day-to-day Corps Chief work would be performed by the an Assistant Corps Chief. It was further decided to establish an Office of The Assistant Corps Chiefs at the AMEDD Center & School. The establishment of this activity is presently underway. The intent is to establish the Assistant Corps Chief as the branch proponent and in turn hold him/her accountable for developing a long-range branch strategy including an appropriate career development plan. Further, the Office of the Assistant Corps Chief is to represent the branch to all external agencies, accrediting organizations, and professional groups, as required. If such representation requires a presence in the Washington, D.C. area, then an element of the Assistant Corps Chief office could be forward deployed to the NCR.

The Office of the Assistant Corps Chief is also accountable for integrating the diverse activities of the various Corps representatives assigned throughout the AMEDD Center and School; e.g., within APPD, the Directorate of Combat Developments, the

academic departments, etc. Establishment of the Office of the Assistant Corps Chiefs is also intended to legitimize a parochial chief representative for each branch.

4. Leader Development/General Officer Distribution

A major design objective of the restructured MEDCOM was to assign general officers to the most complex roles in the MEDCOM. The overall intent was to get "Generals to do General's work". Historically, the number and type of General Officer authorizations allocated to the AMEDD was heavily influenced by branch (Corps) considerations. For example, Title 10 specifies that the Dental Corps chief will be a major general; Title 10 also authorizes an Army Nurse Corps Brigadier General position.

Until recently, some AMEDD general officers were often assigned full time to specific established positions; e.g., the chief of the Army Nurse Corps was dual hatted as the Assistant Surgeon General for Resource Management and Personnel; or sometimes the Chief of the Medical Service Corps was dual-hatted as the ASG for Personnel. The two Dental Corps Brigadier Generals were assigned to HSC and 7th MEDCOM as Deputy Commanders and Directors of Dental Services. Typically Medical Corps General officers were utilized to command Medical Centers and as Commanders of the AMEDD major subordinate commands.

This assignment process served the Army and the AMEDD well until recently. The establishment of the MEDCOM, however, coupled with a loss of several general officer authorizations

caused the TSG to revisit the general officer assignment process. A critical element of the restructured MEDCOM was the creation of Health Service Support Areas (HSSAs). The HSSA structure corresponded to the existing medical center structure. Commanders of each HSSA were dual-hatted as MEDCEN commanders.

During the same period, the AMEDD came under considerable pressure to assign general officers to ASD(HA) and to the Joint Staff. With the advent of lead agency, ASD(HA) assumed a much more active role in health care operations. Each of these developments reduced the amount of flexibility the TSG had regarding how best to employ his general officer cadre. Accordingly, he decoupled Corps Chief work from the Corps Chief general officer role. He also received permission to establish a number of corps immaterial general officer roles. Finally, TSG intended to decouple the HSSA commander role from the MEDCEN commander position. This strategy is currently underway; e.g., the Euro HSSA commander will not be dual hatted as the Landstuhl Medical Center Commander.

A major problem associated with establishing branch immaterial general officer positions is the quality of the leader development process for each branch. Some AMEDD branches currently do not provide sufficient command opportunities at the lower ranks to adequately develop a cohort capable of commanding at the senior ranks. Thus, a major challenge facing the AMEDD is an overhaul of the leader development process to ensure that each corps has ample opportunities to develop an adequate pool of

qualified officers to compete for flag rank.

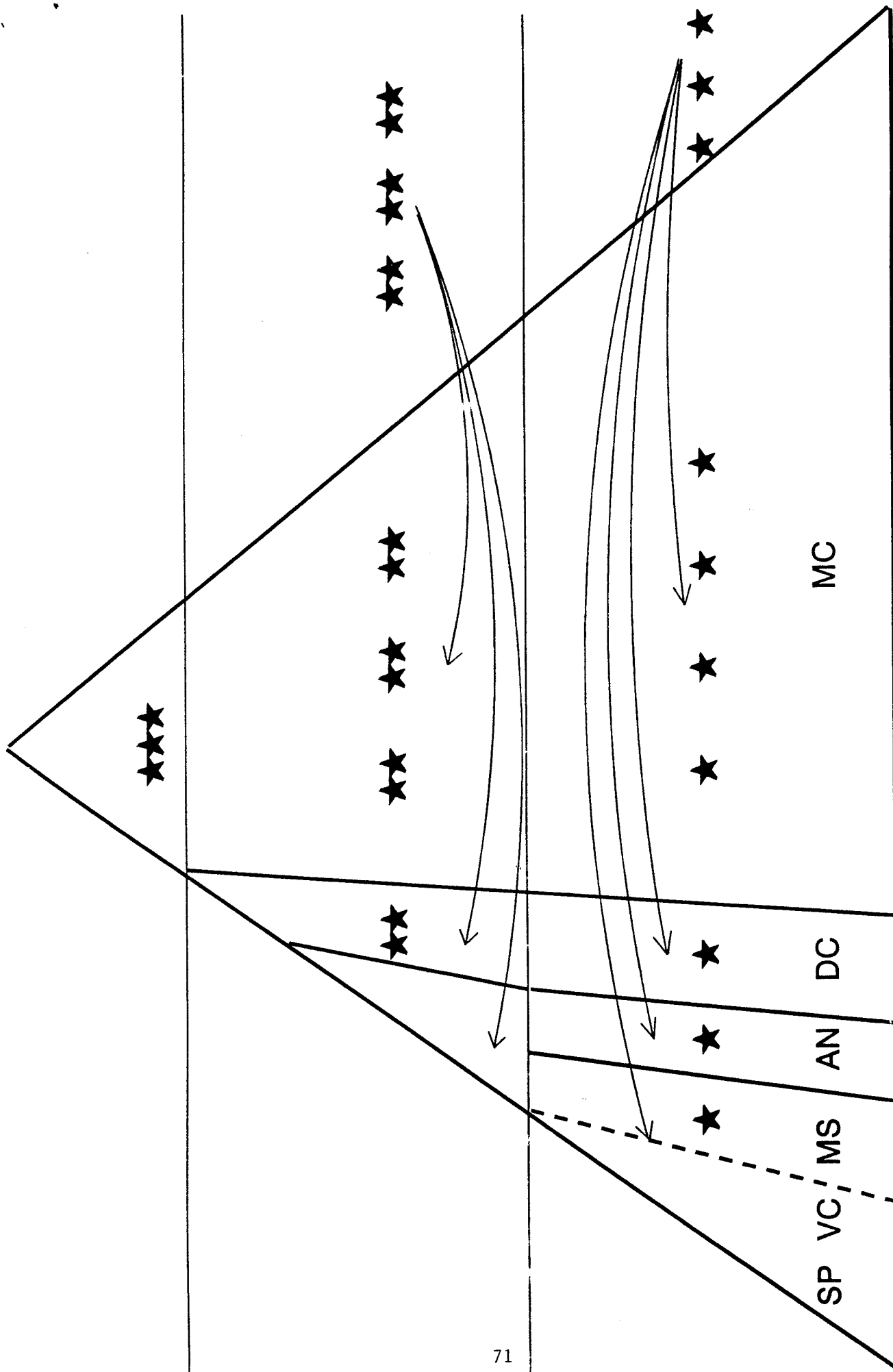
The establishment of branch immaterial general officer positions did not obviate the need for some corps specific authorizations. For example, in order to select a Surgeon General there should be at least three MC major generals to choose from. Hence, general officer floors were established for certain Corps (see Figure 8).

V. CONCLUSION

The AMEDD reorganization described in this document was precipitated by a plethora of factors. The reorganization is far from complete, but profound progress has been made toward realizing the AMEDD vision. Bringing Task Force Aesculapius to closure does not represent an endpoint; significant change still needs to occur to fully implement the redesigned AMEDD.

Recognizing we are on a path of incremental change, Task Force Aesculapius and the AMEDD realize we have not created the perfect solution. In fact, a number of modifications and refinements have already been made to the original concept. As LTG LaNoue said during the initial stages: "We are shooting for the seventy percent solution; we won't get it perfect".

The new MEDCOM supports the AMEDD vision, linking AMEDD assets worldwide into a high-quality, cost-effective, and accessible health care organization serving the Total Army Family across the globe. The reorganized AMEDD is streamlined and flattened, transformed into a seamless organization that connects



AMEDD G.O. BENCH

FIGURE 8

the sustaining base directly to the battlefield. Previous functional overlaps, inefficiencies, and operational voids have been eliminated. The MEDCOM integrates key organizational and doctrinal changes within the Army and health care that position the AMEDD to be more effective and efficient into the next century.

The Chief of Staff of the Army has always held TSG accountable for medically-related matters. By dual-hatting TSG as the MEDCOM Commander, he now has the authority for administering worldwide health care commensurate with his accountability. The major subordinate commands of the MEDCOM are better organized around specific product lines, accountable to the MEDCOM Commander, and better linked to provide their various services to the soldier, family members, and eligible beneficiaries.

This document has presented the background factors leading to the AMEDD reorganization, the analytical process used, the approval process, outcomes of concept development, and implementation of the concept. In addition to providing an overview of the reorganization and activities of Task Force Aesculapius, the purpose in writing such a document is to provide future AMEDD reorganization initiatives with a reference to glean lessons learned and rationale for making organizational changes.

VI. REPORT PREPARATION

This report of the 1993-1995 AMEDD Reorganization was

prepared as a part of the overall reorganization effort. It is intended to be a historical record of the work of redesigning the AMEDD and a reference document for future analyses. The narrative report was prepared by COL John Miller, Dr. Steven D. Clement, LTC Clyde Hoskins, and MAJ Howard Schloss under the leadership of BG Russ Zajtchuk. Enclosures are a compilation of work by all members of TFA I and II; Organizational Design, Incorporated; the MEDCOM Strategic Planning Office; the OTSG Manpower Division; all TFA Work Group participants; and numerous other individuals involved in the reorganization effort.

A copy of this document is being filed with the Defense Technical Information Center for preservation and future distribution.